CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1878	Date: December 18, 2009
	Change Request 6701

SUBJECT: Revisions in Timeliness Requirements for Forwarding Misfiled Appeal Requests

I. SUMMARY OF CHANGES: This change request (CR) makes two changes related to the timeframe involved in processing misfiled appeal requests. This CR also applies to misfiled first level redetermination requests, and to third level ALJ hearing requests.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 19, 2010
IMPLEMENTATION DATE: January 19, 2010

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/310.1/Filing a Request for Redetermination
R	29/330.3/Forwarding Requests to HHS/OMHA

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
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):
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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1878	Date: December 18, 2009	Change Request: 6701

SUBJECT: Revisions in Timeliness Requirements for Forwarding Misfiled Appeal Requests

Effective Date: January 19, 2010
Implementation Date: January 19, 2010

I. GENERAL INFORMATION

A. Background: As part of an initiative to establish consistent rules, and in recognition of the resources required to meet our operational guidelines, this change request (CR) makes two changes related to the timeframe involved in processing misfiled appeal requests. This CR also applies to misfiled first level redetermination requests, and to third level ALJ hearing requests.

B. Policy: The Medicare claims 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, as amended by BIPA, required changes to the Code of Federal Regulations Part 42 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	
6701.1	Contractors shall process misfiled redetermination requests to the proper contractor within 30 calendar days of receipt.	x	x	x	x	x					
6701.1.1.	Contractors shall maintain a record of the cases that are forwarded.	x	x	x	x	x					
6701.2	Contractors shall process misfiled ALJ hearing requests to the proper Office of Medicare Hearings and Appeals (HHS) field office within 30 calendar days of receipt.	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:
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): James Bumgardner (james.bumgardner@cms.hhs.gov)
Post-Implementation Contact(s): James Bumgardner (james.bumgardner@cms.hhs.gov)

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* 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),* include 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.

310.1 - Filing a Request for Redetermination

(Rev. 1878; Issued: 12-18-09; Effective/Implementation Date: 01-19-10)

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. Also, for beneficiaries there are special rules described below in subsection A.

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. 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. 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). In cases of redeterminations filed on behalf of the beneficiary, the contractor 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. However, the contractor may send the individual filing on behalf of the beneficiary a notice including information on how to become a representative of the beneficiary and what the individual should know if the individual fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, will not be the official representative).

Persons who often act on behalf of a beneficiary in filing a redetermination request include: the spouse, parent, daughter or son, sister or brother, or neighbor/friend. Beneficiary advocacy groups and Members of Congress may also submit a request for redetermination on behalf of a beneficiary (see below for further discussion on requests submitted by Members of Congress). Even though someone other than his/her appointed representative makes the redetermination request on behalf of a beneficiary, all written notices related to the appeal must be sent only to the beneficiary, not the individual making the request for redetermination.

Although the contractor may have honored a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, only the beneficiary or representative should be contacted or consulted for further information when processing the redetermination and when issuing the determination (unless the requestor is the beneficiary's legal guardian, in which case no appointment is required).

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. (See §270, for more information on this subject.)

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 a 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:

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

2. A release of information form developed by the congressional office; or

3. 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 in writing by filing a completed Form CMS-20027. Beneficiaries may also request a redetermination in writing instead of using the form. 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:

"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."

Or 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 indicating what they are appealing and why. There are two acceptable written ways of doing this:

a. A completed Form CMS-20027 constitutes a request for redetermination. The contractor supplies these forms upon request by an appellant. Completed means that all applicable spaces are filled out and all necessary attachments are attached.

b. A written request not on Form CMS-20027. The request contains the following information:

1. Beneficiary name;
2. Medicare health insurance claim (HIC) 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 and signature of the party or the representative of the party.

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.

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. It must note the details of its actions (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

How to handle incomplete requests: If any of the above information referenced in Section 2 is not included with the appeal request, the contractor dismisses it to the State or provider with an explanation of the information that must be included (See §310.6 for more information on dismissals). For beneficiary requests, please refer to § 310.1(B)(1) and §310.6.3.

3. Letters and Calls That Are Considered Inquiries

See Pub. 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;

- It is a request clearly limited to an update 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;

- The party asks only for a second of a notice; or

- There is not an initial determination (see 42 CFR 405.924 for Actions that are initial determinations and 42 CFR 405.926 for Actions that are not initial determinations).

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 conduct a redetermination.

- If the contractor receives a 'request for reconsideration' as misrouted mail, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file within 30 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 fiscal intermediary or A/B Medicare Administrative Contractor (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 misdirected requests are forwarded to the proper contractor jurisdiction within 30 calendar days of receipt.*

330.3 - Forwarding Requests to HHS/OMHA

(Rev. 1878; Issued: 12-18-09; Effective/Implementation Date: 01-19-10)

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 *30* calendar days of receipt. *Contractors shall maintain a record of these cases*.

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 Delaware West Virginia Kentucky	Illinois Indiana Ohio Michigan Minnesota Wisconsin
• **Miami, Florida**	Alabama	Arkansas		

100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Florida Georgia Mississippi North Carolina South Carolina Tennessee	Louisiana New Mexico Oklahoma Texas Puerto Rico US Virgin Islands		
• **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 the Pacific Islands American Samoa	Alaska Idaho Oregon Washington
• **Arlington, Virginia** 1700 N. Moore St., Suite 1600, Arlington, VA 22209	Virginia Maryland District of Columbia			