CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3549	**Date: June 24, 2016**
	Change Request 9600

SUBJECT: Pub. 100-04, Chapter 29 – Appeals of Claims Decisions Update: Revisions to Timeliness Requirements for Forwarding Misfiled Appeal Requests, Reconsideration Request Form, and Guidelines for Writing Appeals Correspondence

I. SUMMARY OF CHANGES: This Change Request (CR) updates Pub. 100-04, Chapter 29 with policy updates on handling of misfiled appeals, changes related to the Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act), and some minor punctuation and grammatical corrections. The timeframe for forwarding misfiled redeterminations and reconsiderations requests to the appropriate contractor has been updated from 30 days to 60 days from the date the request was received in the corporate mailroom. Also included are changes related to Medicare Secondary Payer claims and applicable plan determinations. Additionally, modifications have been made to the Reconsideration Request Form that is included with the model Medicare Redetermination Notice (MRN) to add the appellant's telephone number and email address. The purpose of this change request is to provide additional contact information for the appellant to facilitate communication between the Qualified Independent Contractor (QIC) and the appellant.

EFFECTIVE DATE: July 26, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 26, 2016

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	220/Steps in the Appeals Process: Overview
R	29/230/Where to Appeal
R	29/240.2/Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries
R	29/250.1/Amount in Controversy General Requirements
R	29/250.2/Principles for Determining Amount in Controversy
R	29/260/Parties to an Appeal
R	29/270.1.2.How to Make and Revoke an Appointment
R	29/280.7/Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers
D	29/290.3.2/Reading Levels
R	29/300.1/General Information
R	29/310.1/Filing a Request for Redetermination
R	29/310.2/Time Limit for Filing a Request for Redetermination
R	29/310.4/The Redetermination
R	29/310.5/The Redetermination Decision
R	29/310.6/Dismissals
R	29/310.7/Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)
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/Contractor Responsibilities - General
R	29/320.7/QIC Jurisdictions
R	29/320.8/Tracking Cases
R	29/330.1/Requests for an ALJ Hearing

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: 3549	Date: June 24, 2016	Change Request: 9600

SUBJECT: Pub. 100-04, Chapter 29 – Appeals of Claims Decisions Update: Revisions to Timeliness Requirements for Forwarding Misfiled Appeal Requests, Reconsideration Request Form, and Guidelines for Writing Appeals Correspondence

EFFECTIVE DATE July 26, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 26, 2016

I. GENERAL INFORMATION

A. Background: This Change Request (CR) is a response to requests for clarifications from the Medicare Administrative Contractors regarding the handling of misfiled appeals. In addition, this CR formalizes changes implemented by the Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act).

B. Policy: N/A

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	
9600.1	Contractors shall observe that the term **Applicable Plan** has been added, and the definition for **Provider of Services** has been expanded in the Glossary.	X	X	X	X					RRB
9600.2	Section 200.C - *Actions That Are Not Initial Determinations* – Contractors shall observe the clarifications made to identify determinations which are not considered initial determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act.	X	X	X	X					RRB
9600.3	Section 210 - *Who May Appeal* – Contractors shall observe the clarification of appeal rights of non-participating providers in Medicare and non-participating suppliers who have furnished items or services to a beneficiary on an assignment-related basis.	X	X	X	X					RRB
9600.4	Section 210 - *Who May Appeal* – Contractors shall observe the addition of applicable plans as parties to	X	X	X	X					RRB

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	an initial determination.									
9600.5	Section 240.2.A - *Conditions* – Contractors shall observe the addition of conversion of the beneficiary's Medicare documents to an alternate format as a condition that establishes grounds for good cause for late filing by beneficiaries.	X	X	X	X					RRB
9600.6	Section 270.1.2.A.1 - *Completing a Valid Appointment of Representative (Form CMS-1696)* – Contractors shall observe clarification to instructions, the circumstances under which a Health Insurance Claim Number (HICN) is required.	X	X	X	X					RRB
9600.7	Section 270.1.2.B.5 - *Required Elements for Written Request (if not using the CMS-1696 form)* – Contractors shall observe that this exception states that an applicable plan appointing a representative does not require a unique identifier.	X	X	X	X					RRB
9600.8	Section 290.3.2 - *Reading Levels* – Contractors shall observe that the subsection on use of formulas to establish reading level has been removed. Contractors shall continue to follow the instructions contained within Section 290.3 – *How to Establish Reading Level* and 290.3.1 – *Writing in Plain Language* to develop appeals correspondence in a manner calculated to be understood by beneficiaries.	X	X	X	X					RRB
9600.9	Section 320.1.B - *Requests Submitted to the Wrong Contractor* – Contractors shall observe the clarification of how a contractor shall correctly re-route a request for a reconsideration that has been misfiled with a MAC.	X	X	X	X					RRB
9600.10	Section 310.1.B.6 - *Letters and Calls That Are Considered Inquiries*– Contractors shall observe the clarification of policy and revision to the timely handling of a misfiled appeal request.	X	X	X	X					RRB
9600.11	Section 310.2 – *Time Limit for Filing a Request for Redetermination* – Contractors shall observe the additional guidance provided in determining the date a request was misfiled with a contractor.	X	X	X	X					RRB
9600.12	Section 310.4.A - *Timely Processing Requirements* – Contractors shall observe the clarification of when to	X	X	X	X					RRB

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	complete and mail a redetermination notice following receipt of a misfiled request.									
9600.13	Section 310.7 - *Who May File an Appeal* –Contractors shall observe changes to the Reconsideration Request Form included in the Medicare Redetermination Notice (MRN).	X	X	X	X					RRB

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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Rosemary McCann, 410-786-2182 or Rosemary.McCann@cms.hhs.gov , Katherine 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

110 - Glossary

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 (DHHS), 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 ALJ 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.

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.

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.

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. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 SSAs Web site 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 DHHS 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 483.12*;

(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, 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 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 a reopening. 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 of the Claims-Processing Manual for more information on the reopening process.

210 - Who May Appeal

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

A person or entity with a right to appeal an initial determination is a 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.

220 - Steps in the Appeals Process: Overview

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

Regulations at 42 CFR 405.940-405.942 provide that a party to a redetermination that is dissatisfied with an initial determination may request that the contractor make a redetermination. The request for redetermination must be filed within 120 days after the date of receipt of the notice of the initial determination (the notice of initial determination is presumed to be received 5 days after the date of the notice unless there is evidence to the contrary). Contractors cannot accept an appeal for which no initial determination has been made. The

parties specified in §210 who are dissatisfied with a determination on their Part A or B claim have appeal rights.

The appeals process consists of five levels. The appellant must begin the appeal at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps the appellant must take before appealing to the next level. Each level is discussed in detail in subsequent sections. If the appellant meets the procedural steps at a specific level (including the amount in controversy (AIC) requirement if applicable), the appellant (and all other parties to the appeal decision) is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination or decision to the next higher level, until appeal rights are exhausted. Although there are five distinct levels in the Medicare appeals process, the redetermination, level 1, is the only level in the appeals process that the contractor performs.

When an appellant requests a reconsideration with a QIC (level 2), the contractor must prepare and forward the case file to the QIC. Further, the contractor may have effectuation responsibilities for decisions made by the QIC. The contractor, however, does not have responsibility for reviewing the QIC's decision for accuracy. When an appellant requests an Administrative Law Judge (ALJ) hearing (level 3), the QIC must prepare and forward the case file to the DHHS Office of Medicare Hearings and Appeals (OMHA). Further, the contractor may have effectuation responsibilities for decisions made at the ALJ, Departmental Appeals Board (DAB)/Appeals Council, and Federal Court levels.

In the chart below, levels 1 – 5 are part of the Administrative Appeals Process. If an appellant has completed all the first 4 steps of the administrative appeals process and is still dissatisfied, the appellant may appeal to the Federal courts, provided the appellant satisfies the requirements for obtaining judicial review.

CHART 1 - The Medicare Fee-for-Service Appeals Process

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination*	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	Current AIC requirements can be found on CMS.gov at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html. See §250 for additional information.
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of the Appeals Council decision	Current AIC requirement can be found on CMS.gov at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html. See §345 for additional information

*__NOTE:__ If a party requests QIC review of a contractor's dismissal of a request for redetermination, the time limit for filing a request for reconsideration is 60 days from the date of receipt of the contractor's dismissal notice.

230 - Where to Appeal

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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**
Redetermination	**MAC**	**MAC**

Reconsideration	**QIC**	**QIC**
ALJ Hearing	**DHHS OMHA Central Docket**	**DHHS OMHA Central Docket**
Appeals Council Review	**Appeals Council**	**Appeals Council**

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

240.2 - Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries

*(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)***A. Conditions**

Good cause may be found when the record clearly shows, or the beneficiary alleges, that the delay in filing was due to one of the following:

- Circumstances beyond the beneficiary's control, including mental or physical impairment (e.g., disability, extended illness) or significant communication difficulties;
- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the beneficiary (e.g., a party is not notified of her appeal rights or a party receives inaccurate information regarding a filing deadline);

  NOTE: Whenever a beneficiary is not notified of his/her appeal rights or of the time limits for filing, good cause must be found.
- Delay resulting from efforts by the beneficiary to secure supporting evidence, where the beneficiary did not realize that the evidence could be submitted after filing the request;
- When destruction of or other damage to the beneficiary's records was responsible for the delay in filing (e.g., a fire, natural disaster);
- Unusual or unavoidable circumstances, the nature of which demonstrates that the beneficiary could not reasonably be expected to have been aware of the need to file timely;
- Serious illness which prevented the party from contacting the contractor in person, in writing, or through a friend, relative, or other person;
- A death or serious illness in his or her immediate family*;*
- A request was sent to a Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired*; or*
- *The beneficiary's Medicare documents were converted to an alternate format (e.g., large print, Braille, etc.).*

B. Examples

Following are examples of cases where good cause for late filing is found. This list is illustrative only and not all-inclusive:

- Beneficiary was hospitalized and extremely ill, causing a delay in filing;
- Beneficiary is deceased. Her husband, as representative of the beneficiary's estate, died during the appeals filing period. Request was then filed late by the deceased husband's executor;
- The denial notice sent to the beneficiary did not specify the time limit for filing for the redetermination; and
- The request was received after, but close to, the last day to file, and the beneficiary claims that the request was submitted timely.

250.1 - Amount in Controversy General Requirements

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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). The amount in controversy thresholds figures are published annually in the Federal Register (http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR). Current AIC amounts can be found on the CMS.gov Web site at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html

250.2 - Principles for Determining Amount in Controversy

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

As part of the requirements for a hearing before an ALJ, a party to a proceeding must meet the AIC provisions at *42 CFR 405.1006*, including the threshold amount, as adjusted, in accordance with *42 CFR 405.1006(b)*.

The AIC is computed as the actual amount charged the individual for the items and services in question, reduced by –

(a) Any Medicare payments already made or awarded for the items or services; and

(b) Any deductible and coinsurance amounts applicable in the particular case.

In such cases where payment is made for items or services under section 1879 of the Act or under 42 CFR 411.400 or the liability of the beneficiary is limited under 42 CFR411.402, the AIC is computed as the amount that the beneficiary would have been charged for the items or services in question if those expenses were not paid under 42 CFR 411.400 or that the liability was not limited under 42 CFR 411.402, reduced by any deductible and coinsurance amounts applicable in the particular case.

After processing the reconsideration, the QIC shall send written notification to all parties. This notice shall include any information concerning the parties' rights to an ALJ hearing, including the applicable AIC requirements and aggregation provisions.

260 - Parties to an Appeal

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

Any of the persons/entities referenced in §210 are parties to an appeal of a claim for items or services payable under Part A or Part B and, therefore, may appeal the initial claim determination and any subsequent administrative appeal determinations or decisions made on all claims for items or services (assuming other requirements, such as filing within prescribed time limits are met).

270.1.2 - How to Make and Revoke an Appointment

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (CMS-1696) or use a conforming written instrument (see subsection B below, for required elements of written instruments). A party may appoint a representative to assist with filing a claim, or at any time during the course of an appeal. In order to constitute a valid appointment, the CMS-1696 or other conforming written instrument must contain a handwritten ink signature of the representative and the party, and each individual must sign the written instrument within 30 days of the other. (See subsection A, below, for exceptions.) By signing the appointment, the representative indicates his/her acceptance of being appointed as representative. The form CMS-1696 can be found at: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html

A handwritten ink signature means the scripted name or legal mark of an individual, handwritten by that individual and executed or adopted with the present intention to authenticate a writing in a permanent form.

CMS permits the use of a rubber stamp in lieu of a handwritten ink signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his or her inability to sign their signature due to their disability. By affixing the rubber stamp, the person is certifying that they have reviewed the document.

A. Completing a Valid Appointment of Representative (Form CMS-1696)

The CMS-1696 is available for the convenience of the beneficiary or any other party to use when appointing a representative. Following are instructions for completing the form.

1. The name of the party making the appointment must be clearly legible. If the party being represented is the beneficiary, the Medicare number *(also known as a Health Insurance Claim Number or HICN)* must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number should be provided. *If the party being represented is an applicable plan in an appeal under 42 CFR §405.924(b)(16), the space may be left blank. A HICN is required only when the beneficiary is the party appointing a representative.*

2. **Completing Section I** – "Appointment of Representative"- The party making the appointment includes their handwritten ink signature, address, and phone number. If the party that wishes to appoint a representative is a beneficiary, then only the beneficiary or the beneficiary's legal guardian may sign. If the party making the appointment is the provider or supplier, the provider or supplier (or person authorized to act on behalf of the provider or supplier) must sign the form and complete this section. The date the party signs the form must be included.

3. **Completing Section II** – "Acceptance of Appointment"- A specific individual must be named to act as representative in the first line of this section; a party may not appoint an organization or group to act as representative. The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed signs the form with a handwritten ink signature, dates and completes the rest of this section.

4. **Completing Section III** – "Waiver of Fee for Representation"- This section must be completed when the beneficiary is appointing a provider or supplier as representative, and the provider or supplier being appointed has furnished the items or services that are the subject of the appeal.

5. **Completing Section IV –** "Waiver of Payment for Items or Services at Issue" – This section must be completed when the beneficiary is appointing a provider or supplier who furnished the items or services that are the subject of the appeal and the appeal involves issues described in §1879(a)(2) of the Act (limitation on liability).

If any of the required elements listed above are missing from the appointment, or are determined to be invalid (e.g. the signature does not meet the requirements of this section), the appointment is considered defective. See §270.1.6 for additional information on processing appeals with an incomplete or invalid appointment.

Prohibition Against Charging a Fee for Representation

A provider or supplier that furnished items or services to a beneficiary may represent that beneficiary on the beneficiary's claim or appeal involving those items or services. However, the provider or supplier may not charge the beneficiary a fee for representation in this situation. Further, the provider or supplier representative being appointed as representative must waive any fee for such representation. The provider or supplier representative does this by completing section III of the CMS-1696. Alternatively, the provider or supplier must include a statement to this effect on any other conforming written instrument being used, and must sign and date the statement.

Waiver of Right to Payment for the Items or Services at Issue

For beneficiary appeals involving a liability determination under §1879 of the Act where the provider or supplier that furnished the items or services at issue is also serving as the beneficiary's representative, the provider or supplier must waive, in writing, any right to payment from the beneficiary for the items or services at issue (including coinsurance and deductibles). The provider or supplier representative does this by completing section IV of the CMS-1696 or other conforming written instrument, and must sign and date the statement.

The prohibition against charging a fee for representation, and the waiver of right to payment from the beneficiary for the items or services at issue, do not apply in those situations in which the provider or supplier merely submits the appeal request on behalf of the beneficiary or at the beneficiary's request (i.e., where the provider or supplier is not also acting as representative for the beneficiary), or where the items or services at issue were not provided by the provider or supplier when the provider or supplier has been appointed as the beneficiary's representative.

B. Required Elements for Written Request (if not using the CMS-1696 form)

As set forth in 42 CFR 405.910(c), a written request for an appointment of representation must:

(1) Be in writing, signed (with a handwritten ink signature) and dated by both the party and the individual agreeing to be the representative;

(2) Provide a statement appointing the representative to act on behalf of the party, and authorizing the adjudicator to release identifiable health information to the appointed representative;

(3) Include a written explanation of the purpose and scope of the representation;

(4) Contain both the party's and appointed representative's name, phone number, and address;

(5) Contain a unique identifier of the party being represented. If the party being represented is the beneficiary, the Medicare number must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number should be provided. *(Exception: An applicable plan appointing a representative in an appeal under 42 CFR §405.924(b)(16) is not required to include a unique identifier)*;

(6) Include the appointed representative's professional status or relationship to the party; and

(7) Be filed with the entity processing the party's initial determination or appeal.

Providers or suppliers that are representing a beneficiary and that furnished the items or services at issue must complete a "Waiver of Fee for Representation". In addition, if the appeal involves a liability determination under §1879 of the Act, the provider or supplier must also complete a "Waiver of Payment for Items or Services at Issue". See §270.1.2.A.4 and 5.

C. Revoking an Appointment

The party appointing a representative may revoke the appointment at any time by providing a written statement of revocation to the contractor.

280.7 - Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

The appeals process remains in effect for all claims with service dates prior to the effective date of exclusion. An excluded provider, physician, or supplier, or the beneficiary may appeal such claims. In addition, if the billing privileges of a provider, physician, or supplier are revoked retroactively, and the contractor reopens previously paid claims to assess an overpayment against the excluded party, the excluded party (or the beneficiary) may appeal the revised initial determination and overpayment under the claims appeal process (*42 CFR part 405 subpart I*).

NOTE: A provider or supplier's appeal of a revocation or denial of billing privileges is processed in accordance with the procedures set forth in *42 CFR part 405 subpart H* and *42 CFR part 498* (see also, IOM 100-08, Chapter 15, §15.25). The contractor is bound by the terms of the revocation action unless billing privileges are reinstated under the enrollment appeals process.

300.1 - General Information

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

The basis for policy governing the disclosure and confidentiality of information collected by the contractor is §1106 of the Act, the Department's Public Information regulations, as well as the Privacy Act, and the Freedom of Information Act. In general, all information relating to an individual is confidential except as provided by regulation. In the interest of an appellant's right to due process, there are situations where information may be disclosed. The CMS regulations implementing §1106 of the Act can be found at *42 CFR Part 401, Subpart B*. (See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.)

In addition, §1106 in title XI of the Act provides penalties for violation of the provisions concerning confidentiality of information. Activities prohibited under the provisions of the Act include, but are not limited to, making false and fraudulent statements, fraudulent concealment of evidence affecting payment benefits, false impersonation of another individual, misuse or conversion of payments for use of another, and improper disclosure of confidential information. (See the Medicare Program Integrity Manual 100-08.)

310.1 - Filing a Request for Redetermination

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 signed copy of their MSN, by filing a completed Form CMS-20027 or by submitting a signed 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. The contractor supplies these forms upon request by an appellant. "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 Web site at: http://www.cms.gov/cmsforms/downloads/cms20027.pdf

b. A written request/letter. At a minimum, the request shall contain 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.

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.

3. Requirements for a Valid Signature on an Appeal Request:

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A **written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.

- An **electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.

- A **stamp signature or other indication that a "signature is on file"** on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request **shall not** be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

4. 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.

5. 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., 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. The contractor shall not issue a second dismissal notice to the appellant.

6. 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.

310.2 - Time Limit for Filing a Request for Redetermination

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

A party must file a redetermination request within 120 days of the date of receipt of the notice of initial determination (MSN or RA) with the contractor indicated on the notice of initial determination (receipt of the notice of initial determination is presumed to be 5 days after the date of the MSN or RA unless there is evidence to the contrary). The date of filing for requests filed in writing is defined as the date received by the appropriate contractor in the corporate mailroom, the date received via facsimile, or the date received in the secure Internet portal/application. If the party has filed the request in person with the contractor, 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 *or filed in person* the request for redetermination to a CMS, SSA, RRB office, or another contractor or Government agency within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired, the contractor *shall consider the date the request was first filed with a contractor or an official Federal government entity as the date of receipt for purposes of determining if the redetermination request was filed in a timely manner.*

When the filing deadline for a redetermination ends on a Saturday, Sunday, legal holiday, or any other nonwork day, the contractor shall apply a rollover period that extends the filing deadline to the first working day after the Saturday, Sunday, legal holiday, or other nonwork day. For example, if the filing deadline for a redetermination falls on the Saturday before Columbus Day, the filing deadline is extended to the first working day after the Columbus Day holiday.

The contractor may extend the period for filing if it finds the party had good cause for not requesting the redetermination timely. (See §240.2 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing, received via hard copy mail, through a facsimile, or through a secure Internet portal/application. If the contractor finds that the party did not have good cause for failing to request a redetermination in a timely manner, it may, at its discretion, consider reopening. (See Pub. 100-04, chapter 34.)

310.4 - The Redetermination

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

A. Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of (D)(4) below). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application. *For misfiled redetermination requests, the proper contractor jurisdiction must complete and mail a redetermination notice within 60 days of receiving the misfiled request in their corporate mailroom.*

Completion means:

1. For affirmations (unfavorable decisions), the date the decision letter is mailed to the parties. Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application, and a hard copy decision letter 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.

2. For partial reversals (partially favorable decisions) and full reversals (fully favorable decisions), when all of the following actions have been completed:

a. The decision letter, if applicable, is mailed to the parties. If the redetermination is processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application, and a hard copy decision letter 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, and

b. The actions to initiate the adjustment action in the claims processing system are taken. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.

3. For withdrawals and dismissals, the date the dismissal notice is mailed. If the redetermination is processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application, and a hard copy decision letter 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.

B. Development of the Appeal Case File

The reviewer must obtain and review all available, relevant information needed to make the determination. All information considered by the appeals adjudicator in conducting the redetermination must be included in the case file. Other areas within the contractor may have information relevant to the claim(s) at issue. For example, the medical review area may submit evidence to the reviewer for inclusion in the case file (such as, documentation and correspondence related to provider education on the issues appealed, any notices of review, and specific documentation requests to the provider and third parties). In addition, contractors such as RACs and ZPICs may have other information from their review of claims that they wish to include in the case file. Documentation submitted by a provider, supplier or beneficiary (or other party to the appeal) as part of a prepayment (e.g. medical review or demand bill review) or postpayment (e.g. ZPIC reviews) review must be included in the appeals case file for consideration during the redetermination.

The development of the case file is important not only for the redetermination, but also to prepare for a potential appeal to the QIC. Proper development of the case file will assist the contractor in timely transmitting the case file to the QIC upon request. In instances of large overpayment cases involving many claims, this case file development is extremely important.

For example, with respect to overpayments that are determined through statistical sampling and extrapolation, appellants often challenge the sampling methodology and the extrapolation during the reconsideration or an ALJ hearing. To avoid any documentation issues during subsequent appeals, contractors shall include all information detailed in IOM 100-08, Chapter 8, §8.4.4 related to the sampling methodology and extrapolation in the case file.

When a reconsideration request is filed with the QIC, and the QIC requests a case file for a large overpayment case, it is critical the QIC obtain the case file timely so it can begin adjudication. Therefore, it should be a priority for the contractor to adequately develop case files.

Evidence in the case file must be made available for inspection by an appellant or party upon request. Reviewers must exercise care in determining the weight to give allegations of fraud and abuse where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed

investigation that supports the claim decision (See subsection D, below, for instructions on development of documentation.)

C. Conducting the Redetermination

1. Overview

• The redetermination is an independent review of an initial determination. The individual performing the redetermination must not be the same person who made the initial determination.

• The contractor reviews the evidence and findings upon which the initial determination was based, and any additional evidence the parties submit or the contractor obtains on its own.

• The contractor may raise and develop new issues that are relevant to the claims in the redetermination.

• There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the amount paid, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable.

• If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.

2. [Reserved]

3. Appeal Requests Filed on Resubmitted Claims

For appeals of a specific line item or service, the date of the first MSN or RA that states the coverage and payment decision is the date of the initial determination. Adjustments to the initial claim or claim resubmissions for the same item/service on the same date of service that are included on subsequent MSNs or RAs, but do not revise the initial determination, do not extend/change the appeal rights on the initial determination.

4. Fraud

Although the reviewer may not make a finding of criminal or civil fraud (see §280, "Fraud and Abuse"), the reviewer should review the claim to see if there is sufficient documentation and evidence supporting that the items or services were actually furnished or were furnished as billed.

5. Appeals Involving Overpayments

For appeals that involve overpayments, the contractor shall review all aspects of the overpayment, including the validity of the overpayment, whether the amount of the overpayment was correctly calculated and extrapolated (if applicable), who is responsible for the overpayment, and whether recovery of the overpayment should be waived under §1870 of the Act. For additional information see IOM 100-06 Chapter 3, sections 70 through 110.

If the redetermination involves an extrapolated overpayment and the appellant challenges the validity of the sampling methodology, the contractor reviews the claims in question as well as the methodology used to extrapolate the overpayment amount. For background on how the ZPICs use statistical sampling to estimate

overpayments, see IOM 100-08, Chapter 8, section 8.4. If a reconsideration is subsequently requested, the entire case will be sent.

6. Evidence

Appellants have the opportunity to submit written evidence and arguments relating to the claim at issue. Contractors must accept and consider any relevant documentation submitted. Contractors may also accept this information via facsimile and/or a secure Internet portal/application.

D. Requests for Documentation

1. Requesting Documentation for State-Initiated Appeals

The reviewer should not request documentation directly from a provider or supplier for a State- initiated appeal. If additional documentation is needed, the reviewer should request that the submitter of the appeal (i.e., the State or the party authorized to act on behalf of the Medicaid State Agency) obtain and submit necessary documentation. The requested documents may be submitted via facsimile or via a secure Internet portal/application. Documentation previously submitted by the State or the provider/supplier as part of a demand bill review must be included in the appeals case file for review during the redetermination (see §310.4.B).

2. Requesting Documentation for Provider or Supplier -Initiated Appeals

For provider and supplier initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider or supplier of the timeframe the provider or supplier has to submit the documentation. The reviewer documents his/her request in the redetermination case file. The requested documents may be submitted via facsimile and/or via a secure Internet portal/application. In some situations, a provider or supplier may inform the reviewer that it is having trouble obtaining supporting documentation from another provider or supplier (e.g., an ambulance supplier who is requested to submit hospital admission records). In this situation, the contractor may assist the provider or supplier in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. See §310.4.D.4. below for information on the extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting Documentation for Beneficiary-Initiated Appeals

For beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the beneficiary (either in writing or via a telephone call) when the reviewer has asked the beneficiary's provider or supplier for additional documentation. The reviewer also notifies the beneficiary that the provider or supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, the reviewer will decide based on the evidence in the case file. If the reviewer sends the beneficiary a letter, it must include a description of the documentation that has been requested.

4. Extension for Receipt of Additional Documentation

Contractors shall educate parties to include all supporting documentation with the redetermination requests submitted via mail, facsimile or a secure Internet portal/application. However, when a party submits additional evidence (via mail, facsimile or a secure Internet portal/application) after filing the request for redetermination, the contractor's 60-day decision- making timeframe is automatically extended for up to 14 calendar days for each submission.

This additional time is allowed for all documentation submitted by a party after the request, even when the documentation was requested by the contractor. Although this extension is granted to the contractor for making decisions, it should not routinely be applied unless extra time is needed to consider the additional documentation.

5. General Information

The contractor routinely includes instructions on the appropriate information to submit with appeal requests in its provider newsletters and other educational literature. Providers and suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.

310.5 - The Redetermination Decision

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

A. Redetermination Decision Letters

The law requires contractors to conclude and mail and/or otherwise transmit the redetermination decision within 60 days of receipt of the appellant's request, as indicated in §310.4. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and/or appointed representative, if applicable).

Contractors shall mail the written decision unless the contractor has received approval from CMS to use a secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically. Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism. Contractors shall ensure that a hard copy decision letter 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.

For partially favorable redeterminations, the contractor mails and/or otherwise transmits the decision letter, and an adjusted MSN or RA to the appellant. The contractor mails a copy of the decision letter and mails or otherwise transmits an adjusted MSN or RA to each party to the initial determination (or the party's authorized representative, if applicable). The contractor shall ensure that the appropriate MSN or RA messages are included regarding refunds of payments, including when necessary any coinsurance or deductible collected.

If a party has an appointed representative, the contractor mails the decision letter to the appointed representative (see §270). Sending the decision letter to the appointed representative has the same force and effect as if the letter was sent to the party. The contractor does not send an MSN or RA to an appointed representative.

For fully favorable redeterminations, the contractor mails or otherwise transmits an MSN or RA reflecting the adjustment action to each party (or the party's authorized representative, if applicable) on the next scheduled release. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable (e.g. applicable coinsurance). The contractor does not send an MSN or RA to an appointed representative.

Unless otherwise specified in its statement of work, contractors are not required to send a fully favorable letter to parties until further notice, except in those situations where the parties will not receive notice of effectuation via an MSN or RA (e.g., MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). In these cases, the contractor mails and/or otherwise transmits via secure Internet portal/application a notice to such parties or authorized/appointed representative if applicable, that references the claims appealed, and briefly explains the outcome of the redetermination.

B. Determinations That Result in Refunds to a Beneficiary

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the contractor must include the following language in the redetermination:

"Therefore, you (the beneficiary) are not responsible for the charges billed by (provider's name) except for any charges for services never covered by Medicare. If you (the beneficiary) have paid (provider's name) for these services (including payment of co- insurance and deductible), you may be entitled to a refund. To get this refund, please contact this office and send the following items:

- A copy of this notice,
- The bill you received for the services, and
- The payment receipt, your cancelled check, or any other evidence showing that you have already paid (provider's name) for the services at issue.

You should file your written request for refund within 6 months of the date of this notice."

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the contractor must send a copy of the adjusted RA in the following situations:

1. A nonparticipating physician not accepting assignment who, based on the redetermination, now has a refund obligation under §1842(l)(1) of the Act;

2. A nonparticipating supplier not accepting assignment who is determined to have a refund obligation pursuant to §1834(a)(18), due to a denial under either §1834(a)(17)(B) or §1834(j)(4) of the Act; or,

3. A denial based on §1879(h) of the Act of an assigned claim submitted by a supplier, where it is determined under §1834(a)(18) of the Act that the supplier must refund any payments (including deductibles and coinsurance) collected from the beneficiary.

NOTE: For additional information regarding refund requirements, please refer to IOM 100-04 Chapter 30, sections 140 and 150.

C. Paid Claim Appeals

If a contractor receives a valid appeal request on a claim that was processed and paid subsequent to the filing of that appeal but prior to issuance of the Medicare Redetermination Notice, the contractor shall issue an unfavorable decision letter using the following template or something similar to the appellant:

(Start)
EXHIBIT 1:

Model Redetermination Unfavorable Decision for Paid Claim Appeal

MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF BENEFICIARY:

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

RE: <Include claim identifier or appeal number>

Dear <Appellant Name>:

This letter is to inform you of the decision on your Medicare appeal. An appeal (also known as a redetermination) is a new and independent review of a claim. You are receiving this letter because you requested a redetermination for <SERVICE(S)> on <DATE(S)>.

The redetermination decision is unfavorable because the service(s) in question has(have) already been paid by the MAC on <DATE>. We have evaluated the information submitted and there do not appear to be any errors impacting the payment amount, which is the maximum allowed by Medicare for this service. As a result, we are issuing an unfavorable decision on your request for a redetermination on this claim.

If you disagree that the claim in question was previously processed for payment, and/or you otherwise disagree with this decision, you may appeal to a Qualified Independent Contractor. You must file your appeal, in writing, within 180 days of receipt of this letter, to the following address:
[INSERT QIC INFORMATION]

Sincerely,

NAME, TITLE
CONTRACTOR NAME

(End)
Exhibit 1

310.6 - Dismissals

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

A. Contractor Dismissal of a Redetermination Request

The contractor may dismiss a request for a redetermination under the following circumstances:

1. Request of a Party - A request for redetermination may be withdrawn at any time prior to the mailing or transmission of the decision via a secure Internet portal/application upon the request of the party or parties filing the request for redetermination. A party may request a dismissal by filing a written notice of such request with the contractor or contacting the contractor by telephone. Contractors may accept requests for withdrawal via facsimile and/or a secure Internet portal/application, if approved by CMS. This dismissal of a request for redetermination is binding unless vacated by the contractor or QIC.

2. Dismissal for Cause - The contractor may dismiss a redetermination request, either entirely or as to any stated issue, under either of the following circumstances:

   a. Where the party requesting a redetermination is not a proper party, or
   b. Where the party requesting a redetermination does not otherwise have a right to a redetermination.

3. Failure to File Timely - When a request for redetermination is not filed within the time limit required, and the contractor did not find good cause for failure to file timely, it should dismiss the request.

4. Appointment of Representative is Defective - When an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment form and the appointment is not corrected within the time limit discussed above in §270.1.6.B.1, the contractor dismisses the request.

NOTE: If the appellant resubmits an appeal request with an appointment of representative form, the contractor should consider the request as a duplicate and should not count the resubmission as additional workload. (See Pub. 100-06, the Medicare Financial Management Manual, Chapter 6.)

5. Party Failed to Make A Valid Request - When the contractor determines the provider, supplier, or State failed to make out a valid request for redetermination that substantially complies with §310.1.B.1. or §310.1.B.2.

6. Beneficiary Dies While the Request is Pending - When a beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary

dies while the request is pending, the contractor issues a dismissal when all of the following criteria apply:

(a) The beneficiary's surviving spouse or estate has no remaining financial interest in the case. In deciding this issue, the contractor considers if the surviving spouse or estate remains liable for the services for which payment was denied or a Medicare contractor held the beneficiary liable for subsequent similar services under the limitation of liability provisions based on the denial of payment for services at issue;
(b) No other individual or entity with a financial interest in the case wishes to pursue the appeal; and
(c) No other party filed a valid and timely redetermination request.

7. There is not an initial determination (see 42 CFR 405.924 and §200.B above for actions that are initial determinations and *42 CFR 405.926* and §200.C above for actions that are not initial determinations).

B. Appeal Rights for Dismissals

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to a QIC if they believe the dismissal is incorrect. The reconsideration request must be received by the QIC within **60 days** of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the contractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the contractor for a redetermination. It is mandatory for the contractor to issue a new redetermination decision on any case remanded by the QIC. The new decision is counted in CROWD on the 2590, 2591 and 2592 as appropriate as a "redetermination". A QIC's reconsideration of a contractor's dismissal of a redetermination request is binding and not subject to any further review.
NOTE: QICs shall not include the "Important Information About Your Appeal Rights" insert when issuing a decision on requests to review a contractor's dismissal of a request for redetermination.

C. Vacating a Dismissal

A party to the redetermination may also request that the contractor vacate its dismissal within 6 months of the date of the mailing (and/or other transmission if the contractor is utilizing a CMS approved secure Internet portal/application) of the dismissal notice if good and sufficient cause is established. If the contractor determines that there is good and sufficient cause, the contractor vacates its prior dismissal and issues a redetermination. For the purposes of counting workload in CROWD, this action should be counted as a redetermination and not a reopening.

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

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 Web site 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.

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 of 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 Web site, 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 of 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, your signature, 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 Web site, 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. Signature of Person Appealing: _____ Date: _____
Contractor Number _____ (Contractor number is optional for contractors with only one location for QICs to request case files)

(End) EXHIBIT 4

320.1 - Filing a Request for a Reconsideration

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 health insurance claim number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name and signature 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 Web site 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 joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the *6*1st 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. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 - Contractor Responsibilities - General

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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 Joint Operating Agreement (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.

320.7 - QIC Jurisdictions

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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

One QIC processes 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.

Part B QIC Jurisdictions

South:
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.**

North:
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.

320.8 - Tracking Cases

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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).

330.1 - Requests for an ALJ Hearing

(Rev. 3549, Issued: 06-24-16 Effective: 07-26-16, Implementation: 07-26-16)

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, DHHS/OMHA 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://cms.gov/cmsforms/downloads/cms20034ab.pdf for the hearing request form used when the request follows a QIC reconsideration and *http://cms.gov/cmsforms/downloads/cms5011a-b.pdf* for the hearing request form used when the request follows a *QIO* reconsideration.