CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 985

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JUNE 16, 2006

Change Request 5058

SUBJECT: Appeals Updates

We are recommunicating Revision 985, "Appeals Updates" sent to you via RO-4235/CI-4009, on June 16, 2006, because the Effective/Implementation Date was erroneously stated as June 1, 2006. The correct Effective/Implementation Date is July 17, 2006. All other information contained in this revision remains the same.

I. SUMMARY OF CHANGES: The CR makes several changes to the Claims Processing Manual. Contractors are no longer required to send acknowledgement letters for requests for Hearing Officer hearings, and contractors are no longer required to notify a Qualified Independent Contractor (QIC) of the effectuation amount. Rather contractors are only required to acknowledge receipt of the effectuation notice from the QIC. In addition, several minor changes have been made to the Reconsideration Request Form and the section on the Departmental Appeals Board process.

NEW/REVISED MATERIAL :

EFFECTIVE DATE :July 17, 2006

IMPLEMENTATION DATE :July 17, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/Table of Contents
R	29/60.14.4/Acknowledgement of Request for a Hearing Officer Hearing
R	29/240.2/General Procedures to Establish Good Cause
R	29/310.7/Medicare Redetermination Notice (for partly or

	fully unfavorable redeterminations)
R	29/320.3/Contractor Responsibilities - General
R	29/320.9/Effectuation of Reconsiderations

R	29/ 330.3/Forwarding Requests to HHS/OMHA
R	29/ 330.5/Effectuation Time Limits & Responsibilities
R	29/340/Departmental Appeals Board - The Fourth Level of Appeal
R	29/ 340.2/Effectuation of Appeals Council Orders and Decisions
R	29/340.3/Requests for Case Files
R	29/340.4/Payment of Interest on Appeals Council Decisions
R	29/345.2/Effectuation of U.S. District Court Decisions

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 985	Date: June 16, 2006	Change Request 5058

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I. GENERAL INFORMATION

A. Background: The CR makes several changes to the Claims Processing Manual. Contractors are no longer required to send acknowledgement letters for requests for Hearing Officer hearings, and contractors are no longer required to notify a Qualified Independent Contractor (QIC) of the effectuation amount. Rather contractors are only required to acknowledge receipt of the effectuation notice from the QIC. In addition, severalminor changes have been made to the Reconsideration Request Form and the section on the Departmental Appeals Board.

B. Policy: Refer to sections 60.14.4, 240.2, 310.7, 320.2, 320.3, 320.9, 330.3, 330.5, 340, 340.2-340.4, and 345.2 for the new policies.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5058.1	Contractors shall discontinue sending acknowledgement letters for Hearing Officer hearing requests.			X	X					
5058.2	Contractors shall revise their Reconsideration Request Forms in accordance with this CR.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5058.3	Contractors shall discontinue reporting a final payment adjustment and effectuation amount to the QIC.	X	X	X	X					
5058.3.1	Contractors shall acknowledge receipt of the effectuation notice from the QIC.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 17, 2006 **Implementation Date:** July 17, 2006 **Pre-Implementation Contact(s):** Maria Ramirez, 410-786-1122 **Post-Implementation Contact(s):** Maria Ramirez, 410-786-1122 or Lisa Childress, 410-786-6956	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev. 985, 06-16-06)

60.14.4 - Acknowledgment of Request for a Hearing Officer Hearing

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

Contractors are no longer required to send acknowledgment letters.

240.2 - General Procedure to Establish Good Cause

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

A. Establishing Good Cause for Beneficiaries When Insufficient or No Explanation or Evidence Was Submitted

If the appellant is a beneficiary, and there is insufficient or no explanation for the delay and no other evidence that establishes the reason for late filing, the contractor dismisses the redetermination request. In the dismissal letter, the contractor informs the beneficiary that he or she may submit an explanation that good cause exists for late filing. The contractor informs the beneficiary that he or she must send the explanation to the contractor within 6 months of the dismissal of the redetermination request and ask the contractor to vacate the dismissal. If an explanation or other evidence is then submitted at a later date, but within 6 months from the dismissal that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the contractor (as applicable) makes a favorable good cause determination. Once the contractor makes a favorable good cause determination, the contractor considers the appeal to be timely filed and proceeds to vacate the dismissal and perform a reopening.

B. Establishing Good Cause for Providers, Physicians or Other Suppliers When Insufficient Evidence/Documentation Was Submitted

When a provider, physician, or other supplier has failed to establish that good cause for late filing of an appeal request exists, the contractor dismisses the appeal request as untimely filed. In the dismissal letter, the contractor informs the provider, physician, or other supplier that they can provide additional evidence or documentation that good cause for late filing exists. The contractor informs the provider, physician, or other supplier that they must send the explanation and the evidence within 6 months from the date of the notice of dismissal of the redetermination request and ask the contractor to vacate the dismissal.

If the provider, physician, or other supplier submits evidence to the contractor within 6 months of its dismissal that supports a finding of good cause for late filing, the contractor makes a favorable good cause determination. However, for late filings of providers, physicians or other suppliers, it should not routinely find good cause. If the contractor makes a favorable good cause determination, it must consider the appeal to be timely filed and proceed with conducting the redetermination. If the contractor does not find good cause, the dismissal remains in effect.

The closed date is the date of the dismissal, and the dismissal is reported on the Appeals Report (Form CMS-2590 and CMS-2591 or CMS-2592, when applicable).

310.7 - Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

The contractor uses the following Medicare Redetermination Notice (MRN) format or something similar and standard language paragraphs.

NOTE: This is a model letter and should be adjusted on a case by case basis if necessary. 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 fill-in-the-blank information (specific to each redetermination) are in italics. 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 FI or carrier to request the case file from.

A. Redetermination Letterhead

The redetermination letterhead must follow the instructions issued by CMS for carrier written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

Medicare Appeal Decision

MONTH, DATE, YEAR
APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

If the appellant is a provider or supplier, in the beneficiary's letter include the following statement: **This is a copy of the letter sent to your provider/physician/supplier.**

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: name of item or service).

The appeal decision is
(Insert either: **unfavorable.** Our decision is that your claim is not covered by Medicare.

OR **partially favorable**. Our decision is that your claim is partially covered by Medicare.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor. You must file your appeal, in writing, within 180 days of receiving this letter. However, if you do not wish to appeal this decision, you are not required to take any action.

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. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

Summary of the Facts

Instructions: You 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 above claim is not covered by Medicare. We have also determined that you are responsible for payment for this service."

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 what policy (LCD, NCD), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it includes an explanation of why the claim can or cannot be paid. 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: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal

Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please 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 and Suppliers Only: Any evidence indicated in this section should be submitted with the request for reconsideration. All evidence, including

evidence indicated in this section, must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence to the Administrative Law Judge or further appeal unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor.

Option 2:

Special Note to Medicare Physicians and Suppliers Only: All evidence should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence to the Administrative Law Judge or further appeal unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor.

Sincerely,

Reviewer Name
Contractor Name
A Medicare Contractor

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 company that is independent from <Insert Contractor's name>.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. 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 medical records, doctors' letters, 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, you should 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 and your appointed representative must sign, date and send us a statement naming that person to act for you. Call us to learn more about how to name a representative.

Help With Your Appeal: 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 call 1-800-MEDICARE (1-800-633-4227) for information on how to contact your local SHIP. Your SHIP can answer questions about payment denials and appeals.

Other Important Information: If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, please write to us at the following address and attach a copy of this letter:

Contractor Name,

A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:

1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-800-486-2048

Contractor Logo or CMS Logo with Contractor Name and Address	**Reconsideration Request Form**	Redetermination/ Appeals Number: XXXXXX

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. *To help us serve you better, please include a copy of the redetermination notice with your reconsideration request*.

QIC Name Address

1. Name of Beneficiary: _____
2. Medicare Number:_____
3. Provider Name:_____
4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative
5. 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*
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. Printed 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)

320.3 - Contractor Responsibilities - General

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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 misrouted or misfiled reconsiderations requests in accordance with § 320.1(B).

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

Complying with the appropriate JOAs.

320.9 - Effectuation of Reconsiderations

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

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

If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision. *The receipt of effectuation information shall be reported to the appropriate QIC.*

Prior to paying a provider of services in fully or partially reversed reconsideration decisions for Part A claims where the beneficiary was previously liable, the FI ascertains whether the provider has been reimbursed for the previously denied services from another source and, if so, it withholds the Medicare reimbursement until the party has assured in writing that the incorrect collection has been refunded or otherwise disposed of.

The FI advises the beneficiary that he/she should expect refund from the provider if payment in excess of the deductible and coinsurance amounts had been made for the

services for which Medicare will pay or for which the provider has been found to be liable.

For Part A cases where written assurance is needed, the FI effectuates within 30 days of receipt of written assurance.

330.3 - Forwarding Requests to HHS/OMHA

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

A. Address for OMHA

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

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

1700 N. Moore St., Suite 1600, Arlington, VA 22209	District of Columbia			

B. Implied Requests for ALJ Hearings

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

The component within the Departmental Appeals Board (DAB) that conducts the fourth level of appeal is the Medicare Appeals Council (herein "the Appeals Council"). The acronym MAC is used throughout the regulations at 42 CFR, part 405, subpart I, however in this manual section the MAC will be referred to as the Appeals Council.

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

330.5 - Effectuation Time Limits & Responsibilities

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

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

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

The FI advises the beneficiary that he/she should expect refund from the provider if payment in excess of the deductible and coinsurance amounts had been made for the

services for which Medicare will pay or for which the provider has been found to be liable.

For Part A cases where written assurance is needed, the FI effectuates within 30 days of receipt of written assurance.

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

A. No Agency Referral

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

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

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

B. Agency Referral

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

1. If the *Appeals Council* accepts the agency referral for review, the AdQIC advises the contractor to delay effectuation until the *Appeals Council* takes further action.

2. If the Appeals Council declines to review the agency referral, the AdQIC advises the contractor to effectuate the decision.

340 – Departmental Appeals Board/Appeals Council - The Fourth Level of Appeal

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

The level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued, but before judicial review is available is Appeals Council review.

If a party requests the Appeals Council to review an ALJ's decision, the Appeals Council may review the decision and adopt, modify, or reverse the ALJ's decision, or remand the case to an ALJ for further proceedings. See, in general 42 C.F.R § 405.1108. However, when a party requests that the Appeals Council review an ALJ's dismissal, the Appeals Council may deny review or remand the case to an ALJ for further proceedings. In addition, the Appeals Council will decide cases that are escalated from the ALJ level without an ALJ decision or dismissal. See 42 C.F.R § 405.1108(d).

340.2 - Effectuation of *Appeals Council* Orders and Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

340.3 - Requests for Case Files

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

340.4 - Payment of Interest on *Appeals Council* Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

345.2 - Effectuation of U.S. District Court Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

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

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