Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-183 **Date: DECEMBER 13, 2001**

This Program Memorandum re-issues Program Memorandum AB-00-122, Change Request 1348 dated December 7, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1348

SUBJECT: Appeals of Medicare Part A/Part B Coverage Determinations

This Program Memorandum (PM) clarifies CMS's policy on appeals submitted by providers, suppliers, or Medicaid State agencies or the party authorized to act on behalf of the Medicaid State agency for Medicare Part A or Part B claim determinations, including coverage determinations, not without fault determinations, and limitation of liability determinations. This PM also revises the CMS policy by removing the requirement that the Medicaid State agency, or its agent, secure written beneficiary authorization prior to its submitting an appeal request to CMS or its Medicare contractors.

This PM refers to appeal requests at the first level of appeal (i.e., requests for reconsideration (Part A) and requests for review (Part B)).

Right to an Appeal From a Medicare Part A or Part B Coverage Determination

A beneficiary's right to an appeal for a Medicare Part A or Part B coverage determination is afforded by statute (see §1869, 1842(b)(3)(c) of the Social Security Act (the Act)). The Act provides for a hearing where a beneficiary is dissatisfied with the determination of the amount of benefits payable under Part A or Part B (including a determination where such amount is determined to be zero). The statute also provides for appeal rights for providers and suppliers in certain circumstances (see §1879(d) of the Act). By regulation, CMS has further established administrative appeals remedies for resolving such disputes that must be exhausted prior to securing a right to a hearing. The regulations governing administrative appeals for Part A coverage determinations are found at 42 CFR Part 405, Subpart G (Reconsiderations and Appeals Under Medicare Part A) and for Part B coverage determinations at 42 CFR Part 405, Subpart H (Appeals Under the Medicare Part B program). These regulations also provide for appeal rights with respect to determinations that a beneficiary, provider, or supplier was not without fault regarding an overpayment under §1870 of the Act; or knew or reasonably could be expected to know that the item or service was not covered, under §1879 of the Act.

Part A:

Regulations at 42 CFR 405.711 require that a request for reconsideration be made in writing and filed at an office of CMS, the Social Security Administration or, in the case of a qualified railroad retirement beneficiary, at an office of the Railroad Retirement Board. The request must be filed within 60 days after the date of receipt of notice of initial determination. Intermediaries can not accept an appeal for which no initial determination has been made. A request for reconsideration that is filed with the intermediary that received the request for payment submitted on behalf of the individual is considered to have been filed with CMS as of the date it is filed with the intermediary.

(See Medicare Intermediary Manual, Part 3 (MIM) §3781.5 - Time Limits for Filing Appeals.) CMS has delegated the authority to extend the time for filing a request for reconsideration to its intermediaries through manual instruction. (See MIM §3781.6 - Finding Good Cause for the Late Filing of Reconsideration Requests.)

A request for reconsideration may be filed on Form CMS-2649, Request for Reconsideration of Part A Health Insurance Benefits; however, a signed written statement expressing disagreement with the initial determination or indicating that a review or a reexamination should be made, and containing the necessary information (as outlined under Contents of an Appeal Request) constitutes a request for reconsideration (see MIM §3782.1). This form is located on the cms.hhs.gov Web site at http://www.cms.hhs.gov/forms/cms-2649.pdf.

Contractors should not accept implied request for reviews from providers, suppliers or States or the party authorized to act on behalf of the Medicaid State Agency. MIM §3782.1 is superseded in this respect and will be updated to reflect this change. Returned remittance advices, listings or computer printouts that are not signed and/or do not express disagreement with a specified initial determination should be returned to the sender.

Part B:

Regulations at 42 CFR 405.807 provide that a party to an initial determination that is dissatisfied with such initial determination may request that the carrier (and in some cases, the intermediary) review such determination. The request for review must be filed within 6 months after the date of the notice of the initial determination. Carriers can not accept an appeal for which no initial determination has been made. CMS has delegated the authority to extend the time limit for filing an appeal to its carriers through manual instructions (see MCM §12007 - Extension of Time Limit for Filing an Appeal) and to its intermediaries through manual instructions (see MIM §3792 - Extension of Time Limit for Filing an Appeal).

See Medicare Carriers Manual, Part 3 (MCM) §12010 and 12015, subsection D. See MIM §3793 and 3794.3, subsection D.

A request for review may be filed on Form CMS-1964, Request for Review of Part B Medicare Claim; however, a signed written statement expressing disagreement with the initial determination or indicating that a review or a reexamination should be made, and containing the necessary information (as outlined under Contents of an Appeal Request) constitutes a request for review (see MCM §12010.1) A copy of Form CMS-1964 is located on the cms.hhs.gov Web site at http://www.cms.hhs.gov/forms/cms-1964.pdf.

Contractors should not accept implied request for reviews from providers, suppliers or States or the party authorized to act on behalf of the Medicaid State Agency. MCM §12010.1.C is superseded in this respect and will be updated to reflect this change. Returned remittance advices, listings or computer printouts that are not signed and/or do not express disagreement with a specified initial determination should be returned to the sender.

Development of Requests for State-Initiated Appeals

Medicare intermediaries and carriers (hereinafter contractors) should not request documentation from a provider or supplier for a State-initiated appeal. If additional documentation is needed, contractors 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. For appeals currently in development, contractors may follow-up with the State or the party authorized to act on behalf of the Medicaid State agency, as needed, and complete the appeals based on the information available.

Also, States or the party authorized to act on behalf of the Medicaid State agency may request a review by telephone, if the appeal request is not complex. If an appeal from the State or the party authorized to act on behalf of the Medicaid State agency is complex or if significant documentation is needed to adjudicate the appeal request, then a written request for review must be filed within the timely filing period.

Development of Requests for Provider/Supplier-Initiated Appeals

If additional documentation is needed to process an appeal, contractors should request that the submitter of the appeal (i.e., the provider/supplier) obtain and submit it within the prescribed time period following notification of an initial determination.

Providers or suppliers may request a review by telephone, if the appeal request is not complex. If an appeal from a provider or supplier is complex or if significant documentation is needed to adjudicate the appeal request, then a written review must be filed within the timely filing period.

Contents of a Written Request for Reconsideration or Review

For Part A appeals, the Medicare regulation at 42 CFR 405.710 states that a party that is dissatisfied with the initial determination may request a reconsideration of such determination. It is clear that the request for reconsideration must be tied to a specific, identifiable initial determination. However, it is not sufficient to simply identify a beneficiary, or a certain time period, for example. The appeal must not only identify the initial determination with which the party is dissatisfied, but must also meet the requirements for the contents of an appeal request outlined below.

For Part B appeals, the Medicare regulation at 42 CFR 405.807 states that a party who is dissatisfied with an initial determination may request that the carrier review such determination. Again, the request for review must not only identify the initial determination with which the party is dissatisfied, but must also meet the requirements for the contents of an appeal request outlined below.

If a fully-completed Form CMS-2649, Request for Reconsideration of Part A Health Insurance Benefits, or Form CMS-1964, Request for Review of Part B Medicare Claim, is not used to express disagreement with the initial determination, then the appeal request must contain the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and
- Which item(s), if any, and/or service(s) are at issue in the appeal.

Providers/suppliers, Medicaid State agencies or the party authorized to act on behalf of the Medicaid State agency are responsible for submitting documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies. This

documentation may be supplied with the appeal request or at the request of the contractor. Failure to submit requested documentation in a timely manner may result in processing delays.

Who Can Submit Appeal Requests

With the issuance of this PM, Medicaid State agencies and parties authorized to act on behalf of Medicaid State agencies may submit an appeal request on behalf of beneficiaries entitled to Medicare and eligible for Medicaid.

NOTE: On and after the effective date of this PM, the Medicaid State agency or the party authorized to act on behalf of the Medicaid State agency should cease submitting beneficiary authorization forms or other beneficiary representation forms with the appeal request.

Additionally, the following parties may continue to submit an appeal request:

- Providers, as defined in 42 CFR 400.202, with appeal rights as specified in regulation at 42 CFR405.710(b).
- Suppliers (including physicians, as defined in 42 CFR 400.202) with appeal rights as specified in regulations at 405.801(b), accepting assignment on the claim at issue, and suppliers with refund requirements under §1842(l)(1), 1834(a)(18), or 1834(j)(4) of the Act.
- Beneficiaries and their authorized representatives.

Medicare Contractor Responsibilities Include (but are not limited to):

See MIM §3780 et. seq.
See MCM §12000 et. seq.

- Medicare contractors must issue to all providers and suppliers, through contractor bulletins and other available means (e.g., available on Web site), the following sections of this PM:
  - Development of Request for Provider/Supplier-Initiated Appeals
  - Contents of a Written Request for Reconsideration or Review
- Reviews all requests for appeal to ensure that requests meet the requirements listed in this PM and contained in manual instructions.
- Notifies an appellant when a request for appeal has not met the filing requirements.
- Requests documentation, when needed, from the appellant.
- Notifies an appellant of the results of its appeal request.

The effective date for this PM is December 1, 2000. In addition, with regard to written beneficiary authorization, this PM is retroactive to all currently pending requests for appeal from Medicaid State agencies (that is, all pending requests for appeal do not require beneficiary authorization from the Medicaid State agency or its agent).

The *implementation date* for this PM is December 7, 2000.

The *effective date* for this PM is December 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded December 31, 2002.

Providers/suppliers are to contact their appropriate intermediary or carrier.

If you have any questions, contact Lisa Childress at (410) 786-6956.