CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 97 **Date: February 6, 2004**

CHANGE REQUEST 2620

I. SUMMARY OF CHANGES:

Redeterminations are the new first level of appeal under Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Contractors must complete 100% of redeterminations within 60 days and notify appellants of their decisions.

This Change Request informs Medicare carriers and fiscal intermediaries of the implementation of the new model Medicare Redetermination Notice (MRN). The MRN will serve as the model notice that contractors must mail to appellants when contractors make redeterminations. Please note: following the exact format of the model letter is not a requirement. Chapter 29 will be amended after publication of the BIPA 521 final rule.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-4	Transmittal: 97	Date: February 6, 2004	Change Request 2620

SUBJECT: Implementation of New Medicare Redetermination Notice (MRN)

The APASS maintainer and associated FIs are waived from implementing this requirement on July 6, 2004, due to their upcoming transition to the FISS system. However, they must implement this requirement upon transitioning to the FISS system.

I. GENERAL INFORMATION

A. Background: This Change Request (CR) informs Medicare carriers and fiscal intermediaries of the implementation of the new model appeal decision letter. All first level appeals will now be called redeterminations. This CR requires all contractors to apply the business requirements under section II to all redetermination decision letters. Contractors must ensure that all sections of this CR are implemented for redeterminations requested on or after October 1, 2004.

Contractors must use the MRN as a model for their redetermination letters. Contractors must use the attached letter as the new model. This new model letter will supersede current manual instructions regarding review and reconsideration letters. Please note: following the exact format of the model letter is not a requirement.

This CR also informs contactors of the decision-making time frames for redeterminations. Contractors must complete 100% of redeterminations within 60 days.

This CR will require only minimal MCS changes and no changes to the other systems.

B. Law: Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) makes significant changes to the Medicare claims appeal provisions. Specifically, section 1869(a)(3)(C)(ii) requires that contractors mail a written notice of a redetermination decision to the parties of an appeal, consistent with long-standing practice.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amends section 1869 by setting forth requirements for redetermination notices. Section 1869(a)(5) requires the written notice to include the specific reasons for the decision, a summary of relevant clinical or scientific evidence used in making the redetermination, a description of how to obtain additional information concerning the decision, and notification of the right to appeal and instructions on how to appeal the decision to the next level. A contractor must, upon request, provide the party information on the policy, manual, or regulation used in making the decision. Section 1869(a)(4)(B) also requires the notice to be written in a manner "calculated to be understood" by the beneficiary.

Section 940(a)(1) of MMA amends section 1869(a)(3)(C)(ii) of BIPA and establishes that 100% of redeterminations must be completed within 60 days of when the contractor receives the request. BIPA requires that the MRN be mailed to the parties within this 60-day period.

This CR should be implemented within current operating budgets and existing systems with the exception of MCS. The intent of this CR is to 1) implement the statute, and 2) provide a convenient model notice that the intermediaries and carriers can use to implement the redetermination level of the appeals process. Although you have some discretion to deviate from the language in the model MRN, the example has been consumer-tested and found to be readable and understandable to Medicare beneficiaries, as required by MMA.

As we phase in all of the BIPA provisions, there will be further guidance on how contractors should forward cases to the next level of appeal.

C. Provider Education: Intermediaries and carriers shall inform affected providers by posting either a summary or relevant portions of this document on their web site at least 30 days prior to implementation. Also, intermediaries and carriers shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about the MRN is available on their web site.

II. BUSINESS REQUIREMENTS

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

Requirement. #	Requirements	Responsibility
2620.1	**Contractors shall generate the MRN for all first level fee-for-service appeals that are partially favorable or unfavorable.**	All Contractors
2620.2	**Contractors shall send the MRN to the appropriate individuals/entities.**	All Contractors
2620.2.1	Contractors shall send the MRN to the appellant.	All Contractors
2620.2.2	Contractors shall send the MRN to the representative of the beneficiary and/or provider, physician or other supplier when one is appropriately appointed. Contractors shall also send a copy of the letter to the other parties to the appeal, including the party being represented when there is an appointed representative.	All Contractors
2620.3	**Contractors shall produce the MRN using the model letter as a guide. Following the format is NOT required.**	All Contractors
2620.3.1	Contractors shall include the Medicare number of the beneficiary, unless the beneficiary has indicated that he/she does not want this number on their correspondence.	All Contractors
2620.3.2	Contractors shall include contact information including, but not limited to, the contractor's name, address, telephone number, and TTY number.	All Contractors
2620.3.3	Contractors shall write the MRN in understandable language for the beneficiary.	All Contractors
2620.3.4	Contractors shall generate the MRN in a clearly printed and readable format.	All Contractors
2620.3.5	Contractors shall print the MRN on white paper using black ink.	All Contractors
2620.4	**Contractors shall include an introductory section in letter format (immediately after the greeting).**	All Contractors
2620.4.1	Contractors shall include a summary statement that reads: "This appeal decision is <partially favorable or unfavorable.>"	All Contractors
2620.4.2	Contractors shall include a statement that reads "For more information on how to appeal, see the page titled 'Important Information About Your Appeal Rights'."	All Contractors
2620.5	**Contractors shall include the "Summary of the Facts Section."**	All Contractors
2620.5.1	Contractors shall include specific information regarding the appeal: provider, date of service, and type of service.	All Contractors
2620.5.2	Contractors shall include background information.	All Contractors

	This shall include all facts relevant to the claim, such as the specific number and kinds of services reviewed, dates, consultations with medical staff, additional evidence that was submitted, etc.	
2620.6	**Contractors shall include the "Decision " section that will state whether the claim(s) listed in the "Summary of the Facts" section is covered by Medicare and whether the beneficiary is responsible for payment.**	All Contractors
2620.7	**Contractors shall include the "Explanation of the Decision" section.**	All Contractors
2620.7.1	Contractors shall make it clear that a fair and reasonable evaluation took place.	All Contractors
2620.7.2	Contractors shall ensure that the section makes clear why the claim can or cannot be paid.	All Contractors
2620.7.3	Contractors shall explain in a clear and understandable way, the specific reasons that led to the redetermination.	All Contractors
2620.7.4	Contractors shall explain what policy (including coverage determinations, regional medical review policy, and/or national coverage determinations), regulations, and/or laws that were used to make the determination.	All Contractors
2620.7.5	Contractors shall provide a summary of the clinical or scientific evidence used in making the redetermination, as appropriate.	All Contractors
2620.8	**Contractors shall include the "Who is Responsible for the Bill" section**.	All Contractors
2620.8.1	Contractors shall include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements, as applicable, in this section. (See Chapter 30 of the Internet Only Manual for further discussion of limitation of liability under § 1842(l)(1) of the Act, waiver of recovery of an overpayment under § 1870 of the Act, and supplier refund requirements under §§ 1834(a)(18), 1834(j)(4), and 1879(h) of the Act).	All Contractors
2620.9	**Contractors shall include a "What to Include in Your Request for an Independent Appeal" section to identify any specific documentation required to appeal at the Independent Appeal level.**	All Contractors
2620.10	**Contractors should include a section to present any additional relevant information to the appeal, after the "What to Include in Your Request for an Independent Appeal" section.**	All Contractors
2620.10.1	Contractors shall not include sensitive medical information in this section. This includes information regarding psychiatric illness or malignancy **that the beneficiary's physician has stipulated should not be revealed to the beneficiary**. In this event, ask the beneficiary to designate a representative, such as an attorney or physician to receive the notice and insure that the beneficiary's best interests are represented without disclosing the information to the beneficiary.	All Contractors
2620.10.2	Contractors shall include any other required or relevant information not contained elsewhere in the letter in this section.	All Contractors
2620.11	**Contractors shall include a page (or pages) at the end of the decision entitled "IMPORTANT**	All Contractors

	INFORMATION ABOUT YOUR APPEAL RIGHTS".	
2620.11.1	Contractors shall include all of the information presented in the MRN example, on this page.	All Contractors
2620.11.2	Contractors shall include their contact information in the "Other Important Information" section of this page.	All Contractors
2620.11.3	Contractors shall include notification of the right to appeal, and specify the appropriate next level and timeframe within which to file an appeal request.	All Contractors
2620.11.4	Contractors shall specify the address of where to file an appeal request.	All Contractors
2620.11.5	Contractors shall specify how to obtain additional information on the appeal.	All Contractors
2620.12	**Contractors shall prepare a copy of the MRN for all parties and any representatives. Contractors shall retain a copy of the MRN for their records and this may be in electronic form.**	All Contractors
2620.13	**Contractors shall complete 100% of first level appeal decisions within 60 days of receiving the requests. The MRN shall be mailed to the parties before the end of the 60 day decision period.**	All Contractors

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): Janet Miller (410) 786-1588** **Post-Implementation Contact(s): Janet Miller (410) 786-1588**	**These instructions shall be implemented within your current operating budget.**

Attachment: Model Medicare Appeal Decision

MODEL

Medicare Number of Beneficiary:
111-11-1111 A

MEDICARE APPEAL DECISION

Contact Information
If you questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

MONTH, DATE, YEAR

APELLANT'S NAME
ADDRESS
CITY, STATE ZIP

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 made an appeal for *(insert: name of item or service)*.

The appeal decision is
(*Insert either: **unfavorable.** Our decision is that your claim in not covered by Medicare and over/under $100 remains in controversy*.
*OR **partially favorable**. Our decision is that your claim is partially covered by Medicare. and over/under $100 remains in controversy)*

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to *(insert: an Administrative Law Judge (for Part A), a Hearing Officer (for part B))*. You must file your appeal, in writing, within (*insert: 6 months (for Part B) or 60 days (for Part A)* of receiving this letter.

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.

MODEL

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 (including local medical review policy, regional medical review policy, and/or national coverage policy), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it included 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.

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 *(insert: a hearing officer hearing or an Administrative Law Judge (ALJ) Hearing)*

The law requires that at least $100 remain in controversy for you to request *(insert: a Hearing officer hearing or an ALJ Hearing)*. If less than $100 remains in controversy, you may combine the claim or claims that are the subject of this decision with claims from other recently issued redetermination decisions. This is called "aggregating claims." For more information, see the section on aggregating claims below.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within *(insert: 60 days for Part A or 6 months for Part B)* of receiving this letter. Under special circumstances, you may ask for more time to request an appeal.

You should include: your name, address, Medicare number, reasons for appealing, and any evidence you wish to attach. 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:

Contractor Name
Address
City, State Zip

Aggregating Claims: To "aggregate claims" EACH CLAIM included in your request for (*insert: Hearing Officer hearing or ALJ hearing*) must be appealed within *(insert: six (6) months or 60 days*) from the date the decision was issued on the claim and each claim must have already received a redetermination decision.

If you wish to request a (*insert: Hearing Officer hearing or ALJ hearing*) by combining the amounts remaining in controversy from other claims, you MUST clearly state on your request that you are "aggregating claims", AND you must list the specific claims that you are aggregating.

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.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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: 1-800-486-204