Medicare
Carriers Manual
Part 3 - Claims Process

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

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NOTE: This instruction manualizes Change Request 1986, Transmittal B-02-047.

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2003*
IMPLEMENTATION DATE: January 1, 2003

Section 7056, Durable Medical Equipment Regional Carriers (DMERCs) Only—Appeals of Duplicate Claims, is being added to manualize PM B-02-047, Change Request 1986, dated July 24, 2002.

Section 12000, Introduction to the Appeals Process, is being updated with a new note to include the policy in PM B-02-047.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER VII

Section

Notification of Payment

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Payments

Refunds

Overpayments

The following aged check cancellation procedures are recommended for checks which are outstanding beyond six months:

- Where an existing Medicare bank account is being terminated and a new account opened with a different bank, follow the check voiding and reissuance instructions as in §4406.2 of Part I.

- Where a check is not presented for payment within one year from date of issue, cancel the check.

- In all other instances it is entirely within your discretion to determine when to cancel checks beyond the 6-month minimum. Make this determination in light of your usual practices and the commercial practices in your area.

You have no further responsibility for initiating contacts with physicians or suppliers to ascertain why a SMI payment check is outstanding. Do not initiate any further contacts with beneficiaries with respect to stale, dated checks, regardless of their amounts.

Establish controls to document the cancellation of outstanding checks; e.g., a notation of beneficiary's claim file, maintenance of a cancelled check listing.

7056. DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs) ONLY—APPEALS OF DUPLICATE CLAIMS

The DMERCs must afford appeals rights to the initial determination of an item or service only, unless the supplier is appealing whether or not the denied item is actually a duplicate. (See § 12000)

The DMERCs must use the following Medicare Summary Notice (MSN) and remittance messages when denying duplicate claims:

MSN 7.3 – This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.

Spanish – Este servicio/artículo es un duplicado de otro servicio procesado previamente. No tiene derechos de apelación de este servicio, excepto si cuestiona que este servicio es un duplicado. Haga casa omiso a la información sobre apelaciones en esta notification, en relación a sus derechos de apelación, a menos que este apelando si el servicio fue duplicado.

Reason code 18: Duplicate claim/service

Remark Code N111 – This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

12000. INTRODUCTION TO THE APPEALS PROCESS

This section explains the Medicare Part B administrative appeals process available to beneficiaries and physicians or other suppliers dissatisfied with initial determinations and appeal determinations/decisions. It details the levels in the process, along with the procedural steps that must be taken by the appellant at each level. A glossary of Medicare Part B administrative appeals terminology, as defined by CMS, is included at the end of this chapter as an aid in clarifying the Part B administrative appeals process.

Also, included in this section are model letters and/or model language for letters, notices, determinations/decisions, and other appeals correspondence.

12000.1 Initial Determination.--This is the first adjudication (judgment) made by you following a request for Medicare payment for Part B claims under title XVIII of the Social Security Act (hereinafter the Act). A notice of initial determination provides appropriate appeals information to the parties. (See §12002, Parties to an Appeal.)

Examples of determinations that are initial determinations regarding claims for benefits under Medicare Part B include:

- Whether services furnished are covered,
- Whether the deductible has been met, and
- Whether the charges for the services furnished are reasonable.

Two specific instances that are not initial determinations regarding claims for benefits under Medicare Part B are:

- Any determination that CMS or SSA has sole responsibility for making, e.g., whether an independent laboratory meets the conditions for coverage of services; whether a Medicare overpayment claim should be compromised or a collection action terminated or suspended; and

- Any issue or factor that relates to hospital insurance benefits under Medicare Part A.

Further, a party may not appeal your use of the Physician Fee Schedule.

Be advised that non-participating physicians or other suppliers who have not taken assignment do not have appeal rights just because they are now receiving initial determination notices. It is important to be aware that non-participating physicians now have access to more beneficiary information through the remittance advice notice than they had before. Therefore, in the situation where a non-participating physician states that he/she is filing an appeal on behalf of a beneficiary, you must be diligent in your efforts to confirm that the non-participating physician has either been designated as an appointed representative of a party or is indeed filing at the request of the beneficiary.

NOTE: Under §1842(l) of the Act, non-participating physicians have limited appeal rights. (See §12002 below for more information on parties to an appeal.)

NOTE: Durable Medical Equipment Regional Carriers (DMERCs) ONLY: Duplicate items and services billed to the DMERC must not be afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate. See § 7056 for Medicare Summary Notice (MSN) messages and remark codes for use on DMERC duplicate denials.

The initial determination is binding unless a party to the initial determination, such as the beneficiary or a physician or other supplier, requests an appeal. The Medicare Part B administrative appeals process is available to resolve beneficiary, physician, or other supplier questions/concerns about payment and coverage decisions. In instances where appeal rights have been exhausted or lapsed, you may have the authority to reopen your determination. (See §12100, Reopening and Revision of Claims Determinations and Decisions and 42 CFR §405.841, Reopening initial or review determination of the carrier, and decision of a carrier hearing officer (HO).)

12000.2 Steps in the Appeals Process: Overview.--Regulations at 42 CFR §405.807 provide that a party to an initial determination that is dissatisfied with such initial determination may request that you review such determination. The request for review must be filed within 6 months after the date of the notice of the initial determination. Carriers cannot accept an appeal for which no initial determination has been made.

Beneficiaries dissatisfied with a determination on their Part B claim have the right to appeal the initial determination. Physicians or other suppliers may have appeal rights depending upon, in most instances, whether the claim is assigned or unassigned. Medicaid State agencies, or parties authorized to act on their behalf, have appeal rights. The Part B appeals process consists of five levels. Each level is discussed in detail in subsequent sections. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal, except in two specific situations, discussed in §12014.4(A)--Claim for Payment Not Acted Upon with Reasonable Promptness and §12014.4(B)--Reopened Determinations.

The appellant must begin the appeal at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps that must be taken by the appellant before an appeal may be taken to the next level. If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination/decision to the next level in the process. The appellant may exercise his/her right to appeal any determination/decision to the next higher level, until he/she has exhausted his/her appeal rights. Although there are five distinct levels in the Medicare Part B appeals process, the HO hearing, level 2, is the last level in the appeals process that you are responsible for conducting.

When an Administrative Law Judge (ALJ) hearing, level 3, is requested, you must prepare and forward the case file. Further, you may have effectuation responsibilities for decisions made at the ALJ, Departmental Appeals Board (DAB), and Federal Court levels.

In the chart below, levels 1 - 4 are part of the Administrative Appeals Process. If an appellant has completed all the 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.