Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1628

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Chapter XII - Table of Contents	12-1 - 12-4 (4 pp.)	12-1 - 12-2 (2 pp.)
12000.1-12100.17	12-5 – 12-107 (102 pp.)	12-3 – 12-57 (61 pp.)
12900 - Glossary	12-109 - 12-112 (4 pp.)	------
12999 - List of Exhibits	12-113 - 12-126 (10 pp.)	12-101 - 12-126 (26 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: September 27, 2001.*
IMPLEMENTATION DATE: November 15, 2001

Section 12000, Introduction to the Appeals Process, provides a brief description of the contents of §12000.

Section 12000.1, Initial Determination, adds information on what is considered an initial determination and how appeal rights apply. This section includes a description of the notice of initial determination.

Section 12000.2, Steps in the Appeals Process: Overview, adds that Medicaid State agencies, or parties authorized to act on their behalf, have appeal rights. Adds a chart to highlight the time limit for filing a request and the monetary threshold to be met at each level of the appeal.

Section 12001, Carrier Correspondence with Beneficiaries or Other Parties Regarding Appeals, reflects inquires on the status of appeals. The purpose of this section is to provide guidance for inquiries that are specific to appeals and the appeal process.

Section 12002, Parties to an Appeal, revises the old §12005, Review and Hearing Process. Clarifies that neither you nor CMS are considered parties to any appeal. Clarifies that representatives are not considered parties by virtue of being representatives.

Section 12004, Appointment of Representative, revises the old §12019(A) to clarify the procedures for appointment of representative.

Section 12004.1, Introduction, clarifies that a representative may be appointed at any point in the appeal process. Clarifies that the appointment is valid for 1 year from the date signed by the beneficiary or other party making the appointment or from the date the appointment is accepted by the representative, whichever is later. The appointment must be signed and dated by the beneficiary or other party making the appointment.

These instructions should be implemented within your current operating budget.

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.

Section 12004.2, Who May Be a Representative, explains that a specific individual must be named as the representative, not an organization. Provides a list of people who may potentially represent a beneficiary.

Section 12004.3, How to Make and Revoke an Appointment, clarifies that the representative must sign the appointment within 30 days of the date signed by the party.

Adds instructions specific to attorney representatives. The attorney does not need to sign the representative form or written statement. You must verify that the individual is an attorney, if not evident from correspondence. To release beneficiary specific information to an attorney (representing either the provider or beneficiary), the beneficiary must either complete the representative form or a release of information.

Adds instructions for how to complete Form CMS-1696-U4.

Provides the required elements for appointments made not on Form CMS-1696-U4.

Section 12004.4, When to Submit the Appointment, clarifies that an appointment may be submitted to you at any point in the appeal process.

Section 12004.5, Where to Submit the Appointment, clarifies that a completed appointment should be placed in the appeals/claim case file.

Section 12004.6, Rights and Responsibilities of a Representative, adds the rights and responsibilities of representatives. For notices and requests, the appellant is the addressee with the representative receiving a copy. Adds instructions for large, multiple appeal or aggregation of claims where the representative is an attorney. Clarifies that the representative must keep the party informed on the progress of an appeal.

Section 12004.7, Validity of an Appointment Over Time, clarifies that a copy of the appointment must be submitted with every new appeal and is only valid for 1 year on a new appeal (exception for subsequent appeals on the same claim).

Section 12004.8, Timeliness of an Appeal Request and Completeness of Appointment, adds an explanation of how to handle timely appeal requests with incomplete or absent appointment and untimely appeal requests with either an invalid or a valid appointment.

Section 12004.9, Powers of Attorney, clarifies which Powers of Attorney can be considered valid appointments and when.

Section 12004.10, Incapacitation or Death of Beneficiary, discusses non-durable and durable Powers of Attorney. Clarifies who may file on behalf of a deceased beneficiary.

Section 12004.11, Disclosure of Individually Identifiable Beneficiary Information to Representatives, highlights that beneficiary-specific information should not be released to representatives without either a complete appointment or a written authorization.

Section 12006, Amount in Controversy, describes the amount in controversy requirements for each level of appeal and explains the computation of the amount in controversy remaining.

Section 12006.1, Defined, provides a definition for amount in controversy.

Section 12006.2, General Requirements, describes the requirements for amount in controversy at each level of the appeal.

Section 12006.3, Calculating the Amount in Controversy, provides the correct procedures for calculation of the amount in controversy and gives specific instructions for overpayments and exclusions.

Section 12006.4, Additional Considerations for Calculation of the Amount in Controversy, explains the calculation of amount in controversy for HO cases that involve more than one claim.

Section 12006.5, Aggregation of Claims to Meet the Amount in Controversy, specifies that appellants must clearly state that they are aggregating claims in the appeal request. Clarifies that the decision on whether the amount in controversy is met is made by the HO. Explains that cases that have been aggregated do not require a single hearing. Explains the aggregating rules at the ALJ hearing.

Section 12008, Extension of Time Limit for Filing a Request for Review or Hearing Officer (HO) Hearing, clarifies that beneficiaries should be given more leniency while physicians or other suppliers are expected to file appeals on a timely basis and, thus, should not routinely be granted extensions. Adds that good cause should not be considered over the phone. Age is no longer a sole factor in determining good cause for late filing by beneficiaries. However, other factors coupled with age may be considered as an acceptable condition.

Section 12008.1, Good Cause, specifies that for good cause, the time limit for filing may be extended by you or the HO.

Section 12008.2, General Procedure to Establish Good Cause, clarifies that when an appeal is filed late that does not establish good cause for late filing, you should dismiss the case and inform the appellant of the rules for establishing good cause.

Section 12008.3, Conditions that May Establish Good Cause for Late Filing by Beneficiaries, describes some of the situations where a beneficiary has good reason to file late.

Section 12008.4, Examples of Situations Where Good Cause for Late Filing Exists for Beneficiaries, provides examples from the descriptions in §12008.3.

Section 12008.5, Conditions that May Establish Good Cause for Late Filing by Physicians or Other Suppliers, describes some of the situations where physicians or other suppliers have good reason to file late.

Section 12008.6, Examples of Situations Where Good Cause for Late Filing Exists for Physicians or Other Suppliers, provides examples from the descriptions in §12008.5.

Section 12008.7, Good Cause Not Found for Beneficiary, or for Physician or Other Supplier, explains that when good cause is not found you must send a written notice to the beneficiary, physician or other supplier.

Section 12009, Fraud and Abuse, adds that appeal adjudicators should question matters at issue by requesting and receiving evidence and documentation. If information presented appears to be inappropriate or tampered, the adjudicator should refer to either the medical review or fraud and abuse units.

Clarifies that there may be some situations where claims with evidence that items or services were not furnished or were not furnished as billed should be referred to the fraud unit.

Explains that you or the HO does not have authority to suspend reviews or HO hearings at the request of OIG or DOJ without approval and direction from CMS CO.

You must continue adjudicating appeals submitted by physicians or other suppliers who are being or have been investigated, indicted, or convicted of fraud and abuse, subject to the exceptions described in §12009.6.

An appeal adjudicator must remain neutral in the adjudication of claims that involve a physician or other supplier who is being or had been investigated, indicted or convicted of fraud or abuse.

Section 12009.1, Authority, provides the authority under title XVIII of the Social Security Act.

Section 12009.2, Inclusion and Consideration of Evidence of Fraud and/or Abuse, clarifies that if you suspect fraud you should refer documentation to either the medical review or fraud and abuse units for their follow-up. Both these departments may also submit evidence to you for inclusion in the case file.

Section 12009.3, Claims Where There Is Evidence that Items or Services Were Not Furnished, or Were Not Furnished as Billed, clarifies that if you believe that services were not furnished or were not furnished as billed, you should send a copy of your decision to the fraud and abuse unit.

Section 12009.4, Responsibilities of Reviewers and Hearing Officers, clarifies that if you suspect a civil or criminal law violation, you may only make a decision on coverage and payment issues. In making the decision you should consider all evidence and if fraud is suspected you should forward any information to the fraud unit.

Section 12009.5, Requests to Suspend the Appeals Process, clarifies that you do not have authority to suspend appeal at the request of OIG or DOJ without approval of CMS CO.

Section 12009.6, Continuing Appeals of Physicians or Other Suppliers Who are Under Fraud or Abuse Investigations, explains that you must continue to adjudicate the appeal submitted by physicians or other suppliers who are being investigated, indicted, or convicted for fraud, subject to the excepts explained in this section.

Section 12009.7, Appeals of Claims Involving Excluded Physicians or Other Suppliers, explains the appeal rights of excluded physicians or other suppliers.

Section 12010, Guidelines for Writing Appeals Correspondence, provides an overview for the preparation of appeals correspondence, including review determinations and HO hearing decisions. You must also follow all other CMS issued instructions on correspondence guidelines.

Section 12010.1, General Guidelines, explains that you should only write beneficiary correspondence below an eighth grade level if you are in doubt as to his/her comprehension level or if his/her correspondence to you is below an eighth grade level.

Section 12010.2, Letter Format, specifies the requirements for appeals correspondence and appeals determinations/decisions.

Section 12010.3, Required Elements in Appeals Correspondence, explains the specific elements that must be in appeal correspondence.

Section 12011, Disclosure of Information, explains that your fraud unit must be aware that information placed in the case file is accessible to an appellant.

Section 12011.1, General Information, provides basic information on the disclosure of information.

Section 12011.2, Fraud and Abuse Investigations, clarifies that all information placed in the case files is accessible to appellants. You should use caution in situations where fraud and abuse information is placed in the case file.

Section 12011.3, Medical Consultants Used, clarifies that the name and qualifications of any consultant used must be included in the case file.

Section 12011.4, Multiple Beneficiaries, provides instructions for protecting beneficiaries' privacy in hearings involving multiple beneficiaries.

Section 12012, Review - The First Level of Appeal, explains what a review is and some of the basic instructions for reviewers in completing reviews.

Section 12012.1, Filing a Request for Review, clarifies that a request for review may be made in writing or by telephone. Explains that individuals may file on behalf of a beneficiary if there is proof that the beneficiary know of or approved the submission of the request for review, however the individual who filed on behalf of the beneficiary is not the representative of the beneficiary. Clarifies what constitutes a request for review by a physician or other supplier and by the beneficiary.

Section 12012.2, Time Limit for Filing a Request for Review, explains the time limit for filing a request for review and what is considered the date of filing for both telephone and written requests for review.

Section 12012.3, Recording of Inquires and Other Actions on the Carrier Appeal Report (Form CMS-2590), clarifies that inquiries should not be counted as appeals and appeals should not be counted as inquiries.

Section 12012.4, The Review, explains the timely processing requirements of the review. Describes the development of the appeals case file. Explains the elements of a review and how requests for documentation should be handled.

Section 12012.5, The Review Determination, clarifies that the review determination must be sent to the appellant with copies to each party, including the beneficiary if he/she is not the appellant, and to the authorized representative as applicable.

Provides that a claim where the previous denial is upheld on review (unfavorable and partly favorable) must contain the amount remaining in controversy in the review determination letter.

Provides that an EOMB/MSN or RA suffices as a review determination/decision for fully favorable determinations.

Clarifies that partly favorable determinations must still receive a review determination letter.

Clarifies that unfavorable determinations/decisions must still receive a review determination letter.

Clarifies when dismissals of review requests are appropriate.

Section 12012.6, Review Determination Letter, includes model review letter format and standard paragraphs.

Section 12012.7, Effect of the Review Determination, clarifies that the review determination is binding unless there is a HO hearing decision or a reopened and revised determination issued.

Section 12013, Telephone Review Procedures, emphasizes that telephone reviews should be utilized to expedite and simplify the review process.

Section 12013.1, Informing the Beneficiary and Provider Communities About Your Telephone Review Process, explains that you must inform appellants about your review process. This includes informing about limitations that you have for conducting reviews on the telephone.

Section 12013.2, Issues for Telephone Reviews, adds a list of issues you should be able to complete over the telephone, issues that are generally inappropriate, and issues that are inappropriate. (Requests for review can be made on the telephone for both issues that are generally inappropriate and inappropriate.)

Section 12013.3, Issues During the Telephone Review, instructs how to handle issues that cannot be resolved during the telephone review.

Section 12013.4, Time Limit for Requesting a Telephone Review, clarifies that the time frame to file an appeal is 6 months from the date of the initial determination.

Section 12013.5, Review Requests Made on Behalf of the Party on the Telephone, clarifies that appellants may have representatives file requests over the phone as long as a copy of the appointment can be faxed before or during the call.

Section 12013.6, Conducting the Telephone Review, explains that before conducting the telephone review, the caller must provide the beneficiary name, the beneficiary date of birth and Medicare HIC Number.

Section 12013.7, Documenting the Call, provides information that must be documented during the telephone review.

Section 12013.8, Timely Processing Requirements, states that timely processing requirements can be found in §12012.4.

Section 12013.9, Review Determination Letters, explains that review determination letters must be sent even though you inform the appellant of your decision at the end of the call. Review determination letters do not need to be sent in fully favorable decisions as provided in §12012.5.

Section 12013.10, Education, describes the educational activities that must be associated with telephone reviews.

Section 12013.11, Monitoring Telephone Reviews, provides that you must monitor at minimum 45 telephone reviews or 5 percent of telephone reviews per quarter, whichever is less.

Section 12014, Hearing Officer (HO) Hearing - The Second Level of Appeal, explains the Hearing Officer hearing and the qualifications necessary for a HO hearing.

Section 12014.1, Filing a Request for HO Hearing, clarifies that a request must be made in writing and signed by the party making the request.

You must attach the envelope or an image of the envelope to the request for a hearing. In situations where timeliness may become an issue to the hearing, you must maintain the envelope in the case file.

Section 12014.2, Time Limit for Filing A Request for HO Hearing, defines the time limit for filing a request for a HO hearing as 6 months and gives a definition of the date of filing.

Section 12014.3, Request for HO Hearing Filed Prior to a Review Determination, explains that there are two exceptions to the rule that a review determination must be made prior to a HO hearing. These exceptions are described in §12014.4.

Section 12014.4, Exceptions to Filing Requirements, explains that the exceptions to the rule that a review determination must be made prior to a HO hearing are claims for payment that are not acted upon with reasonable promptness and reopened determinations.

Section 12016, Request for HO Hearing, describes the timely processing requirements and carriers' responsibilities for HO hearings.

Section 12016.1, Timely Processing Requirements, explains the processing requirements for HO hearings.

Section 12016.2, Carrier Responsibilities – General, provides that the hearing request and all relevant material must be forwarded to the Hearing Officer Unit no later then 30 calendar days after the request is received.

Section 12016.3, Requests for Transfer of In-Person Hearings, describes how requests for transfers are handled for both the beneficiary and the physician or other supplier. Clarifies the procedures for processing transfer requests.

Section 12016.4, Acknowledgment of Request for HO Hearing, explains that the timeframe to acknowledge a receipt of a hearing officer hearing request is 21 calendar days after receipt of the request.

Section 12016.5, Case File Development, describes the importance of the case file and the information contained within the case file in the HO hearing.

Section 12016.6, Case File Preparation, explains that all evidence/documentation in the HO case file should be put in a set order prior to the HO hearing. Provides a recommended case file order. Contractors should use this case file order or something similar in organizing their HO case files.

Section 12017, Types of Hearing Officer (HO) Hearings, gives details on the three types of HO hearings that are offered to appellants.

Section 12017.1, In-Person Hearing, explains the in-person hearing option.

Section 12017.2, Telephone Hearing, describes the telephone hearing option and explains situations in which the HO can offer a telephone hearing.

Section 12017.3, On-the-Record Hearing and Decision, explains the on-the-record hearing option and the advantages of this option.

Section 12017.4, Preliminary OTR Hearing and Decision, explains that a HO may first prepare a preliminary OTR decision, however, this is not required on all cases. An HO may not make a decision never to conduct a preliminary OTR.

Appellants do not have the right to request a preliminary OTR hearing, nor is the decision of a HO not to issue a preliminary OTR hearing decision subject to appeal.

Adds that an appellant or representative may respond to your decision by other means, including by phone, fax, or electronic mail in lieu of a postcard.

Section 12018, Hearing Officer (HO) Authority and Responsibilities, describes the authority of the Hearing Officer and the general responsibilities and qualifications of a Hearing Officer.

Section 12018.1, Hearing Officer (HO) Authority, provides the limitations to the authority of a Hearing Officer.

Section 12018.2, Qualifications and General Responsibilities, clarifies the scope of work the HO must complete and what qualifications a HO should have to complete this type of work.

Section 12018.3, Disqualification of HO, describes the situations in which the HO should disqualify himself/herself and when disqualification is mandatory.

Section 12019, Hearing Officer (HO) Hearing Procedures, provides details on the procedures for preparation and scheduling of a Hearing Officer hearing.

Section 12019.1, Preparation for the Hearing Officer (HO) Hearing, clarifies that the HO should review the claim prior to sending the notice of hearing. Explains the situations in which a hearing request should be dismissed by the HO and the procedures for dismissing a request.

Section 12019.2, Scheduling the Date, Time and Place of Hearing, clarifies that the notice of hearing should give at least 14 calendars days notice of the scheduled date. Exceptions are given. Describes the notice of hearing and the elements of the written notice.

Section 12019.3, Adjournment and/or Postponement of Telephone or In-Person Hearing, describes the situations in which the HO may postpone a hearing time. Describes the situations in which the HO may adjourn a hearing.

Section 12019.4, Pre-Hearing Review of the Evidence, omits that cases may be sent back to the unit initially responsible for denying the claim or claims when new material evidence is submitted.

Section 12019.5, Forwarding Copies of Cast File Prior to Telephone Hearing, explains that the appellant has the right to request a copy of the case file prior to the telephone hearing; if he/she requests a copy, the HO must provide the appellant with a copy.

Section 12019.6, In-Person and Telephone Hearing Procedures, describes the rights of a party at the in-person or telephone hearing, the opening of the hearing, the opening statement, oaths, affirmations, the penalty provision, principles of questioning, record of the hearing, and the closing of the hearing.

Section 12019.7, The HO Hearing Decision Timeliness, explains that 90 percent of hearing decisions must be issued within 120 days of receipt of the request for the hearing in the corporate mailroom and that the HO must issue a decision within 30 days of completing the hearing. Clarifies that copies of the decision letter must be sent to each party and representative.

Section 12020, Effectuation of HO Hearing Decisions, explains the procedures for the effectuation of HO hearing decisions.

Section 12020.1, General Rule, explains that 90 percent of HO hearing decisions must be effectuated within 15 calendar days of the date of the decision. One hundred percent must be effectuated within 30 calendar days of the date of the decision.

Section 12020.2, Delaying Effectuation, explains that there must be a legally supportable basis for requesting a reopening of a HO's decision. You do not need the RO's approval, however, you may consult them for advice on whether a reopening is necessary.

Section 12020.3, Elements of Written Request for Reopening, describes the procedures for requesting a reopening of the Hearing Officer's decision.

Section 12020.4, Notice to Parties of Reopening Requests, clarifies that a notice must be provided to all parties to the HO decision.

Section 12020.5, HO Reply to Reopening Request, describes what the HO should do if a reopening is requested based on whether or not the revision is determined to be appropriate.

Section 12020.6, Notice to Parties of HO Determinations, explains that the HO must send a reply to a reopening request to all parties regardless of whether it is determined that a reopening is necessary.

Section 12026, Requests for Part B Administrative Law Judge (ALJ) Hearing, explains an appellant's rights to an ALJ hearing.

Section 12026.1, Right to Part B ALJ Hearing, describes how a party must file a request for an ALJ hearing and the timeframe for filing the request.

Section 12026.2, Forwarding Requests to SSA/OHA, provides the address that requests for an ALJ hearing and the case file should be sent to. Changes the timeframe to forward requests to 21 calendar days and 45 calendar days for aggregated cases which exceed 40 beneficiaries.

Section 12026.3, Case File Preparation, explains the case file preparation for ALJ requests. Lists the documents in the case file and explains the document order of the case file. Explains the processing of assembling case files for "big box" cases using a Primary File.

Section 12026.4, Acknowledgement of Request for Part B ALJ Hearings, clarifies that the acknowledgement must be sent within 21 calendar days of your receipt of the request. Model letter is provided in §12026.5.

Section 12026.5, Model Format for Acknowledgement of ALJ Hearing Request, includes a model of an acknowledgement of request for an ALJ hearing.

Section 12028, Review and Effectuation of Part B Administrative Law Judge (ALJ) Decisions/ Dismissals, clarifies that all ALJ decisions must be reviewed in order to determine if there are effectuation responsibilities and to determine if the case should be recommended for an agency referral.

Section 12028.1, Review and Effectuation of ALJ Decisions – General, clarifies that you should only effectuate a formal decision and not on correspondence from a party.

Highlights that when effectuating a decision you must use the payment policies that were in effect on the date the claim was first submitted for processing, unless specifically directed otherwise.

Section 12028.2, Effectuation Time Limits, explains that for ALJ decisions where no agency referral is made, when you effectuate depends on whether a specific amount to be paid is indicated or not. If a specific amount is indicated, you must effectuate within 30 days of receipt of the ALJ decision. If a specific amount is not computed, effectuate the decision within 30 days after you compute the amount to be paid. You must compute the amount due within 30 days of the receipt of the ALJ decision. (For agency referrals, do not effectuate until 30 days of the DAB decision or when advised by the RO, whichever is sooner.)

Section 12028.3, ALJ Data Extraction Form, instructs that the data extraction form should be completed and returned to the contractor that CMS uses to enter and maintain ALJ data.

Section 12028.4, Misrouted ALJ Case Files, explains what should be done when ALJ case files or decisions are sent to the wrong contractor.

Section 12028.5, Duplicate ALJ Decisions, clarifies how you should handle multiple ALJ decisions on one case.

Section 12029, Recommending Agency Referral of Part B ALJ Decisions or Dismissals to the CMS RO (formerly known as the Agency Protest Process), describes the process of submitting draft memorandum of agency referral to the lead RO.

Section 12029.1, Time Limits for Forwarding Agency Referral Memorandum to CMS RO, clarifies that you have 30 days from the date of the ALJ decision to forward your draft memorandum and case file to the lead CMS RO for your region.

Section 12029.2, Guidelines for Reviewing ALJ Decisions/Dismissals, explains the situations in which the DAB will most likely accept an agency referral.

Section 12029.3, Draft Agency Referral Memorandum Content, explains the content of the agency referral memorandum.

Section 12029.4, Draft Memorandum Format, provides a format and guidelines for submitting memorandum to the lead RO.

Section 12029.5, Submission of Draft Agency Referral Memorandum to CMS RO, lists the lead regional offices who accept draft memorandum for each region.

Section 12032 Effectuation of DAB Orders and Decisions, highlights that you should send case files to the DAB in the exact order received from OHA and within 21 days of the DAB's request.

Section 12032.1, Background, explains the level of review available to parties after an ALJ hearing or dismissal.

Section 12032.2, Requests for Case Files, provides instructions for forwarding case files to the DAB.

Section 12032.3, Carrier Effectuation Responsibilities, clarifies that a DAB decision should be completely effectuated within 60 days.

Section 12033 Request for U.S. District Court Review by a Party, clarifies that if you receive a summons or complaint due to a party's request for U.S. District review, send a copy to the address given in this section and notify your RO.

Section 12034, Effectuation of U.S. District Court Decisions, explains that you should contact your RO prior to effectuation of a U.S. District Court decision.

Section 12040, Review and Analysis of Initial Determinations and Appeals Determinations/ Decisions and Dismissals, explains the contents of the appeals analysis program.

Section 12040.1, Introduction, describes the advantages to implementing and carrying out a quality improvement program.

Section 12040.2, Quality Improvement, lists the requirements that should be involved in an adequate quality improvement program.

Section 12040.3, Feedback, explains the contents of a feedback program. A feedback program is one that allows the staff responsible for conducting the prior level of appeal to see the next level of appeal's decision.

Section 12045 Managing Workload, manualizes the prioritization of workload from Transmittal AB-01-02.

Section 12100, Reopening and Revision of Claims Determinations and Decisions, and Subsections 12100.1 to 12100.17, reflects new agency name.

Section 12900, Glossary, defines appeal-related terms.

Section 12999, List of Exhibits, adds Form CMS-5011B as an exhibit and **deletes Exhibits 5 - 15**.

Do not implement the following systems changes until further notice:

Section 12004.6 - Requires copies of notices on actions, determinations, or decisions including MSN/EOMB or RA to be sent to the representative of a party.

Section 12012.5 - Requires the amount in controversy remaining to be in each review determination letter.

Section 12010.2 - Requires long date format instead of numerical dates. Requires bullet points to be used to clarify subject matters that are lengthy or complicated. Requires using complete names instead of abbreviated names.

Section 12012.6 - Allows carriers to issue one review letter for multiple claims.

NOTE: Form CMS-1965, Form CMS-5011B, and Form CMS-3509 are currently only available as HCFA forms. The new CMS forms will be issued as the stock of the older versions is depleted.

CHAPTER XII
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Reopening and Revisions

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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.)

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.

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

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
Review	6 months from date of initial determination	None
Hearing Officer (HO) Hearing	6 months from date of review determination	At least $100 remains in controversy
Administrative Law Judge (ALJ) Hearing	Filed within 60 days of receipt of HO hearing decision	At least $500 remains in controversy (at least $100 for home health services)
Departmental Appeals Board (DAB) Review	Filed within 60 days of receipt of ALJ hearing decision /dismissal	None
Federal Court Review	Filed within 60 days of receipt of DAB decision or declination of review by DAB	At least $1,000 remains in controversy

12001. CARRIER CORRESPONDENCE WITH BENEFICIARIES OR OTHER PARTIES REGARDING APPEALS

NOTE: This section refers to inquiries. The purpose of this section is to provide guidance for inquiries that are specific to appeals and the appeal process. (See MCM, Part 2, §5104 - 5105 for more details on beneficiary and provider services.)

Inquiries regarding the status of appeals must be handled as expeditiously as possible without lowering the quality of the response. Valid appeal requests are not considered inquiries. In order to ensure that all inquiries are handled adequately, the following procedures are required.

A. Required Procedures.--

1. The written inquiry must be stamped with the date of receipt in the corporate mailroom and controlled until a final answer is provided. Telephone and other inquiries (e.g., in-person or electronic) should be logged in and controlled until a final answer is provided.

2. Call-Back Responses.--If a telephone response to an inquiry cannot be completed at the time of the initial inquiry, it must be handled by a substantive call-back within 2 working days. If it is impossible to reply to the inquiry within 2 working days, an interim telephone response must be made within the 2 working days.

3. Inquiries must be answered in accordance with applicable Contractor Performance Evaluation criteria contained in MCM, Part 2, Administrative Review Procedures, §5260.

4. Records must be kept of all inquiries. Appropriate management reports and reports requested by CMS will be produced from these records to aid in assuring that the control standards for the inquiries and the quality of responses to the inquiries are maintained.

B. Standards of Quality of Responses to Inquiries.--Perform a continuous quality appraisal of outgoing letters, computer notices, and responses to requests for appeal. You must have the capability to meet these appraisal requirements. This appraisal must consist of the following five elements:

1. Accuracy.--The information in the letter should be correct with regard to Medicare policy and your data. Taken as a whole, the information will increase the inquirer's overall understanding of the issues that prompted the inquiry.

2. Responsiveness.--The response should address the inquirer's major concerns and state an appropriate action to be taken.

3. Clarity.--Letters should have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use CMS-provided model language and guidelines, where appropriate. All written inquiries are to be processed using a font size of 12, and a font style of Universal or Times New Roman, or another similar style for ease of reading by the beneficiary.

Contractors must make sure that responses to beneficiary correspondence are clear; language must be below the eighth grade reading level, unless it is clear that the incoming request contains language written at a higher level. Contractors may use a software package to verify that responses to beneficiary inquiries are written at the appropriate reading level. Whenever possible, written replies should contain grammar comparable to the level noted in the incoming inquiry.

4. Timeliness.--Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of a beneficiary inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

Every contractor will have the flexibility to respond to beneficiary written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: beneficiary's name and address, telephone number, beneficiary's HIC number, date of contact, internal inquiry control number, subject, summary of discussion, status, action required (if any), and the name of the customer service representative who handled the inquiry.

For provider inquiries, substantive action is taken and an interim or a final response is sent within 30 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 30 calendar days (e.g., inquiry must be referred to a specialized unit for response), send the interim response acknowledging receipt of the inquiry and the reason for the delay.

5. Tone.--The warmth and genuineness of a letter. This brings communication to a more personal level. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

12002. PARTIES TO AN APPEAL

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

- A beneficiary;

- A participating physician or other supplier (i.e., one who has agreed to take assignment on all items or services payable on behalf of a Medicare beneficiary);

- A nonparticipating physician or other supplier taking assignment for a specific item or service has party status for that item or service;

- A nonparticipating physician not taking assignment, but potentially responsible for making a refund to the beneficiary under §1842(l)(1) of the Act, has party status for that claim. Section 1842 (l)(1) gives party status to nonparticipating physicians, for example, where (1) a claim for an item or service is denied as not being reasonable and necessary under §1862(a)(1); (2) where the supplier has already collected payment from the beneficiary for the item or service in question; and (3) where the physician is claiming that he/she did not know and could not reasonably be expected to know that the item or service would be denied as not being reasonable and necessary under §1862(a)(1);

- A nonparticipating supplier of durable medical equipment potentially responsible for making a refund to the beneficiary under §1834(a)(18) of the Act has party status for that claim. (**NOTE:** §1834(a)(18) requires nonparticipating suppliers to make refunds when the suppliers violate the prohibition against unsolicited telephone contacts);

- A supplier of medical equipment and supplies furnishing items or services to a beneficiary not on an assigned basis and responsible for making a refund to the beneficiary under §1834(j)(4) of the Act has party status for that claim;

- A Medicaid State agency, or party authorized to act on behalf of the State; 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 you nor CMS are considered parties to an appeal at any level of the administrative appeals process, and therefore do not have the right to appeal or to participate as a party at any stage in the administrative appeals process. At times, CMS will make an agency referral of an ALJ decision or dismissal to the DAB and ask the DAB to review the ALJ's decision or dismissal under its own motion review authority. (See §12029--Recommending Agency Referral of Part B ALJ Decisions or Dismissals (formerly known as the Agency Protest Process).) At times, an ALJ may ask for your input to a hearing. This does not change your party status.

NOTE: While a representative may request an appeal on behalf of the party that he/she represents, the representative is not considered a party himself/herself solely by virtue of being a representative. (See §12004.6 for the rights and responsibilities of a representative.)

12004. APPOINTMENT OF REPRESENTATIVE

(See 42 CFR §405.870 - Appointment of representative, 42 CFR §405.871 - Qualifications of representative and 42 CFR §405.872 – Authority of representative.)

12004.1 Introduction.--A party may appoint any individual, including an attorney, to act as his/her representative in dealings with you. Although some parties may pursue a claim or an appeal on his/her own, others will rely upon the assistance and expertise of others. A representative may be appointed at any point in the appeals process. A representative may help the party during both the processing and appeal of a claim or claims. The appointment of a representative is valid for 1 year from either 1) the date signed by the party making the appointment, or 2) the date the appointment is accepted by the representative, whichever is later.

NOTE: Representative must sign (see exceptions below for attorney representative) the appointment within 30 calendar days of the party's signature. The appointment remains valid for any subsequent levels of appeal on the claim/service in question unless the beneficiary specifically withdraws the representative's authority. (See §12004.7.) In order for the appointment to be valid, it must be signed and dated by the beneficiary.

12004.2 Who May Be A Representative.--Any individual may be appointed to act as a representative unless he/she is disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law. If you have evidence that the appointment of representative should not be honored, do not accept the appointment. Notify the party attempting to be represented and the individual attempting to represent the party that the appointment will not be honored.

A specific individual must be named as the representative. An organization or entity may not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that confidential beneficiary information is only released to the individual so named.

A physician or other supplier who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative of the beneficiary. To act as the beneficiary's representative, the physician or other supplier must meet the criteria set forth in this section.

If the requestor is the beneficiary's legal guardian, no appointment is necessary.

NOTE: Billing clerks or billing services employed by the physician or supplier to prepare and/or bill the initial claim, process the payments, and/or pursue appeals act as the agent of the physician or other supplier and do not need to be appointed as representative of the physician/supplier. (See MCM, §3060B(10) which allows payment to be made to an agent who furnishes billing or collection services.)

The following is a list of the types of individuals who could be appointed to act as representative for a party to an appeal. This list is not exhaustive, and is meant for illustrative purposes only:

- Congressional staff members;
- Family members of a beneficiary;
- Friends or neighbors of a beneficiary;
- Surrogate decision maker for an incapacitated beneficiary;
- Member of a beneficiary advocacy group;

- Member of a physician or supplier advocacy group;
- Attorneys; and
- Physicians or suppliers.

12004.3 How to Make and Revoke an Appointment.--The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (Form CMS-1696-U4) or submit a written statement (see §12004.3(C) for required elements of written statements). A party may appoint a representative at any time during the course of an appeal. The representative must sign the appointment form or written statement within 30 calendar days of the date the beneficiary or other party signs in order for the appointment to be valid. (See §12004.3(A) below for exceptions.) By signing the appointment, the representative indicates his/her acceptance of being appointed as representative.

A. Attorney Representatives.--If the person representing the party is an attorney, the attorney is not required to sign the representative form or a written statement. (See 20 CFR §404.1707(b) and 42 CFR §405.870.) If it is not evident that the individual representing the party is an attorney from his/her correspondence, you must verify that the individual is an attorney. This may be verified by requesting a business card or letterhead that indicates the person is an attorney or by asking the attorney to submit a written statement stating that he/she is an attorney.

1. In order to release individually identifiable beneficiary information to an attorney representative (of the beneficiary or other party), the beneficiary must either sign and complete an appointment naming the attorney or complete a release of information. Either of these will satisfy the requirements of the Privacy Act.

2. When an attorney has not signed the appointment, consider that the attorney accepted the appointment 30 days from the date of the party's signature. Use that date to determine how old an appointment of representative form or written statement is.

3. If you assume that the attorney accepted the appointment because there was no action within 30 days of the party's signature, send a letter to the beneficiary stating the name of the attorney representing them.

4. Do not assume that the attorney accepted the appointment if you have documentation and/or evidence that negates this assumption or if you have received information from the beneficiary or guardian that the attorney cannot or will not represent the beneficiary. In this situation you should proceed with processing and rendering a decision on the appeal. Send the appeal decision to the parties only (not the attorney). Include an explanation in the decision letter of the reason why the appointment was not accepted and what needs to be done if the party wishes to obtain a representative for further levels of appeals. At your discretion, you may also wish to send a letter to the attorney advising him/her of the reasons why the appointment was not accepted.

A representative should keep a completed appointment on file and submit a copy with each claim appealed (subject to certain restrictions discussed in §12004.7).

B. Completing the Appointment of Representative (Form CMS-1696-U4).--Form CMS-1696-U4, Appointment of Representative form, 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. (See Exhibit 1: Appointment of Representative, Form CMS-1696-U4.)

1. The name of the party making the appointment must be clearly legible. For beneficiaries, the health insurance claim (HIC) number must be provided. For physicians or other suppliers, the provider number must be provided in the HIC number space.

2. Completing Section I.--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 signature, address and phone number of the party making the appointment must be completed, and the date it was signed filled in. Only the beneficiary or their legal guardian may sign when a beneficiary is making the appointment. If the party making the appointment is the physician or other supplier, someone working for, or as an agent of, the physician or other supplier must sign and complete this section.

3. Completing Section II.--The name of the individual being appointed as representative must always be completed, and his/her relationship to the party filled in. The individual being appointed then signs and completes the rest of this section.

NOTE: The attorney exception discussed in §12004.3(A), above, applies here. Therefore, an attorney does not need to sign or date the appointment. However, the attorney does need to provide you with his/her name, address, and phone number. This may be done by completing this section; or it may be done by submitting his/her business card or using his/her letterhead or anything that identifies him/her as an attorney.

4. Completing Section III.-- This section must only be completed when the beneficiary is appointing a physician or other supplier as representative and the physician or other supplier actually furnished the items or services that are the subject of the appeal. In this case only, the individual signing for the physician or other supplier in Section II would then also sign and date Section III.

5. Waiver of Right to Payment from the Beneficiary for the Items or Services at Issue.--This waiver is not present on Form CMS-1696-U4, but must be submitted along with the completed Form CMS-1696-U4 in certain limited situations. (See discussion of this waiver in §12004.3.C. below for complete instructions.)

C. Appointment Made on Other Than Form CMS-1696-U4.--You may not require the use of Form CMS-1696-U4. Any other form or written statement containing all required elements must be accepted as a valid appointment of representative. The required elements are provided in subsection 2, below.

1. Groups (such as a beneficiary advocacy group) or individuals may use their own form or written statement. If all the required elements (see subsection 2, below) are contained on the form, you should accept the form. Although a form developed by an advocacy group may be used, it must meet our guidelines to be accepted. One specific problem that has been encountered with such self-developed forms is that the form is set up to routinely allow someone other than the beneficiary to sign the appointment form on behalf of the beneficiary. For example, some forms provide space for the family member to sign for the beneficiary. Without any documentation of why the beneficiary was unable to sign and absent proof that the person signing on behalf of the beneficiary has the authority to do so. This form would not meet our guidelines. Only the beneficiary may sign the form unless there is proof that the person signing on behalf of the beneficiary has the authority to do so.

2. Required Elements.--The following information must be included on an appointment of representative form or written statement:

- Name/Address/Phone Number of party (i.e., the beneficiary or physician or other supplier).

- Health Insurance Claim Number, when the party making the appointment is a beneficiary.

- Medicare Physician/Supplier Number, when the party making the appointment is a physician or other supplier.

- Name/Address/Phone Number of the individual being appointed as representative.

- A statement that the party (i.e., the beneficiary or the physician or other supplier) is authorizing the representative to act on her or his behalf for the claims at issue and a statement authorizing disclosure of individually identifying information to the representative (in cases where the representative is not the provider of services).

- Signature of the party making the appointment, and the date signed.

- Signature of the individual being appointed as representative, accompanied by a statement that he/she accepts the appointment, and the date signed; however, if the individual being appointed as representative is an attorney, the attorney does not need to accept the appointment in writing. (See §12004.3 (A).)

- Prohibition Against Charging a Fee for Representation: A physician or other supplier that furnished items or services to a beneficiary may represent that beneficiary on his/her claim or appeal involving those items or services. However, the physician or other supplier may not charge the beneficiary a fee for representation in this situation. Further, the physician or other supplier being appointed as representative must acknowledge that he/she will not charge the beneficiary a fee for such representation. The physician or other supplier does this by including a statement to this effect on the form or written statement, and then signs and dates it.

- Waiver of Right to Payment from the Beneficiary for the Items or Services at Issue: For beneficiary appeals involving the denial of the claim on the basis of §1862(a)(1) or (a)(9), or §1879(g) of the Act, and where a limitation on liability determination made under §1879 of the Act determined that both the beneficiary and the physician or other supplier, knew or could reasonably have been expected to know, that the item or service would not be covered, and where the physician or other supplier that furnished the items or services at issue is also serving as the beneficiary's representative, the physician or other supplier must waive, in writing, any right to payment from the beneficiary for the items or services at issue (including co-insurance and deductibles). The physician or other supplier representative does this by including a statement to this effect on the form or written statement, and then signs and dates it.

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 physician or other supplier merely submits the appeal request on behalf of the beneficiary or at the beneficiary's request (i.e., where the physician or other supplier is not also acting as representative for the beneficiary), or where the items or services at issue were not provided by the physician or supplier representative.

D. Revoking an Appointment.--The party appointing a representative may revoke the appointment by providing a written statement of revocation to you at any time.

12004.4 When to Submit the Appointment.--A representative, beneficiary, or other party may submit the completed appointment to you at the time such person files a request for appeal or at any time during the processing of the appeal. If an appeal or other motion is filed by a representative on behalf of a party to the appeal, but does not include an appointment, take the actions specified below in §12004.8(A) to secure the written appointment.

Note that a completed appointment of representative form or written statement, or a copy of such form or statement, must be submitted with each appeal request.

12004.5 Where to Submit the Appointment.--When the appellant or representative submits the original or a copy of the signed appointment of representative form or written statement to you, place it in the claims/appeals case file. The representative should also give the party making the appointment a copy of the completed form.

12004.6 Rights and Responsibilities of a Representative.--In representing an appellant before you, the representative has certain rights and responsibilities.

A. Rights of a Representative.--A representative may exercise any and all rights given to parties on behalf of the person represented. For example, the representative may submit arguments, evidence or other materials on behalf of the appellant. The representative may obtain information from you on the claim(s) and/or appeal(s) at issue, elicit evidence from the appellant or witnesses, make statements about fact and law relating to the case, and request or give notice about proceedings before you. The representative, the party, or both may participate or attend at all levels of appeal. Notices sent to any party on any action, determination, or decision, including the Medicare Summary Notice (MSN), Explanation of Medicare Benefits (EOMB) or remittance advice (RA), and all

requests sent to any party for the production of evidence, must also be sent to the representative of such party. In all such notices or requests, the appellant is the addressee, with the representative receiving a copy of such notice or request.

B. Responsibilities of a Representative.--The appointment of a representative by a party must be made freely and without coercion. You should assume that a representative is not making false or misleading statements, representations or claims about any material fact affecting any person's rights. However if you have reason to believe that he/she is, refer to your internal fraud unit for development. They may contact your RO about disqualifying the representative from appearing before you.

A representative will have access to personal and confidential medical and other information about a beneficiary(ies). You may assume that the representative will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, assume that a representative is not disclosing any personal or confidential medical or other information about a beneficiary(ies) outside of the appeals process.

Unless otherwise directed by the party making the appointment, you do not need to keep the represented party informed of the purpose of the appointment, the scope of the appointment, and exactly when/under what circumstances the appointment will be exercised, as you may assume the representative has taken on this responsibility. Further, the representative should keep the party informed on the progress of an appeal.

In cases of attorney representatives, since the attorney is representing the beneficiary or other party, the attorneys is expected to provide all relevant information to the respective party(ies). Where an attorney is representing large, multiple appeals or aggregation of claims, you do not need to send notices on actions other than determinations to appellants. It is sufficient for the attorney to receive them.

NOTE: You must always send the appellant the appeal determination/decision or dismissal when issued, taking care in situations involving multiple beneficiaries to protect beneficiary privacy rights. (See §12011.4.) Send a copy of the determination/decision to the attorney representative. The determination/decision or dismissal notice must be addressed to the appellant with the representative receiving a copy of the notice.

A physician or other supplier who has provided items or services to the beneficiary and who is acting as representative for the beneficiary with respect to those items or services may not charge the beneficiary a fee for such representation.

Finally, you should assume that the representative will provide the beneficiary or other party making the appointment with a copy of the appointment at the time it is completed.

12004.7 Validity of an Appointment Over Time.--A new appointment of representative form or written statement does not need to be executed each time an appeal is filed by the same representative who is representing the same party. For the administrative convenience of both the party making the appointment and the representative, the representative may maintain a completed appointment on file and then submit a copy with each new appeal request. (See subsections below for more detail.)

A. Appointment of Representative More Than One-Year Old.--An appointment submitted must be no more than 1 year old from the date it was signed by the party making the appointment or from the date accepted by the representative, whichever is later. When an appointment is more than 1 year old and the representative submits a new appeal on a new claim, the representative must secure a newly executed appointment. Allowing the representative to use the same appointment for up to 1 year will help reduce the paperwork involved in representing parties. Requiring that a new form be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.

Upon receipt of an appointment, you may notify the representative of the need to complete a new appointment on a yearly basis. This will make both the party making the appointment and the representative aware of the need for annual filing of an appointment. You may also place information about appointment validity in provider newsletters, bulletins, educational materials, etc.

B. Subsequent Appeals of the Same Claim(s).--The appointment remains valid throughout any and all subsequent levels of administrative appeal on the claim or claims at issue. Therefore, the representative need not secure a new appointment when proceeding to the next level of appeal on the same claim(s). This holds true regardless of the length of time it may take to resolve the appeal.

12004.8 Timeliness of an Appeal Request and Completeness of Appointment.--There will be times where the appeal request is timely, but the appointment is incomplete or inaccurate in some way. Handling these situations depends on who (what party) is attempting to make an appointment. When the beneficiary makes the appointment, provide help and assistance to the beneficiary and representative in securing the appointment, based on the time frames set forth below. When a physician or other supplier makes the appointment, provide instruction on the proper and timely completion of the appointment. The following provides guidance on properly responding to a representative's attempt to submit a request for appeal.

A. Timely Filed Appeal Request With a Appointment Missing or Defective.--There are different rules for missing appointments versus defective appointments.

1. Missing or Defective Appointment When Beneficiary is the Represented Party.--When an individual is attempting to act as the beneficiary's representative, but submits an incomplete or defective appointment of representative form or written statement, you must advise him/her of how to complete the appointment, and you must notify him/her to submit the completed appointment

to you based on the time limits below. You should include in the notice any relevant information the individual should know if he/she fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, he/she will not be the official representative, etc.). Should the form or statement not be corrected within the time limits set forth below, proceed with processing and rendering a decision on the appeal. Send the appeal decision to the beneficiary, as well as, to any other party, but not to the unauthorized representative. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent. However, if you have information or evidence that the appointment was not submitted at the request of the beneficiary, do not conduct the appeal unless and/or until you receive confirmation from the beneficiary that the request was submitted with his/her approval.

When an individual is attempting to act as a representative of an appellant who is a beneficiary but fails to complete an appointment of representative form or a written statement, consider the missing appointment to be an incomplete form or written statement and follow the instructions above. In cases of reviews filed on behalf of the beneficiary, see §12012.1(A); you do not need to develop an absent appointment of representative if the request for review clearly shows the beneficiary knew of or approved the submission of the request for review.

At the HO hearing level, you may not do an in-person or telephone hearing at the request of a family member, friend or other person wishing to act as representative without a valid appointment of representative. If you do not receive a valid appointment of representative within the time limits specified below, the HO should conduct a preliminary OTR following the instructions in §12017.4 (Preliminary OTR Hearing and Decision).

When there is information or evidence that the appeal request and/or the appointment of representative form was not submitted at the request of the beneficiary, you must verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary). In order to verify the wishes of the beneficiary, you may have to send a letter to him/her explaining the situation. The letter should include a return envelope (or be sent out certified mail) and should advise that if no response is received then the appointment of representative will not be honored.

Notify both the alleged representative and the party of the incomplete or defective form or statement and describe the documentation/missing information that is required to execute a valid form or statement. Allow 14 calendar days for a corrected appointment to be submitted. If, at the end of the time allowed a corrected appointment has not been submitted, take the appropriate action.

2. Defective or Missing Appointment When Physician, Other Supplier, or Non-Beneficiary is the Represented Party.--In cases where the beneficiary is not the represented party, notify both the person submitting the appointment and the appellant of the incomplete appointment. Advise them why the appointment is defective, and describe the documentation or missing information that is required to complete the appointment. This may be done by telephone or written notification. A corrected/completed appointment may be submitted to you by facsimile, at your discretion, or by mail within 14 days. Should the form or statement not be corrected within the time limit, dismiss the appeal request and notify, in writing, both the appellant and the person submitting the appointment of your dismissal. Further, the dismissal must state that an appeal request may be resubmitted by anyone (including the representative if he/she has properly completed the appointment) if the time limit for submitting the appeal has not expired. In cases of a HO hearing request, you should route the case to the HO for an appropriate dismissal.

If the individual is attempting to act as a representative of an appellant who is not the beneficiary and fails to include an appointment of representative form or a written statement with his/her appeal request, dismiss the request. Provide the appellant with an explanation of the reason(s) for the dismissal and advise him/her how to complete an acceptable appointment. Advise the appellant of the amount of time remaining, if any, in which an appeal request must be filed to be considered timely. If the appeal request is re-submitted before the time period to appeal expires and the appointment of representative is complete, you must back-out your previous dismissal and accept the appeal request. Consider good cause if the re-submitted request is untimely.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Appointment.--Because an untimely filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing, see §12008 below), an incomplete or defective form or statement may, in some cases, need to be corrected. If an incomplete or defective appointment needs to be corrected, follow the instructions contained in §12004.8, above, prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Appointment.--These cases should be resolved solely on the basis of whether there is good cause. (See §12008.)

12004.9 Powers of Attorney.--Treat a power of attorney as a valid appointment if all the required elements (see §12004.3, above) of a valid appointment are present and the power of attorney authorizes the designated person to conduct the beneficiary's affairs. This can include authorization to conduct personal and financial matters, or a general authorization, or it may include a very specific authorization to pursue benefits under the Medicare program or under Government entitlement programs, for example.

NOTE: A power of attorney that is a valid appointment is exempt from the 1-year validity rules described above in §12004.7.

Do not treat a power of attorney that authorizes the designated person to make health care or medical care decisions as an appointment if the document does not also authorize the designated person to conduct the beneficiary's affairs, as discussed above, or to make financial decisions on behalf of the beneficiary.

Powers of attorney may be durable (i.e., surviving the incapacitation of the beneficiary) or non-durable (i.e., automatically revoked upon the incapacitation of the beneficiary). (See §12004.10, below.)

12004.10 Incapacitation or Death of Beneficiary.--If at any time after the execution of a valid appointment or non-durable power of attorney the beneficiary becomes incapacitated and is unable to manage his/her affairs, the appointment becomes invalid. You must resolve who has legal authority to act on behalf of the beneficiary before disclosing any further information pursuant to the appointment or non-durable power of attorney.

If the beneficiary has executed a durable power of attorney that authorizes the designated person to conduct the beneficiary's affairs, as discussed in §12004.9, above, or to make financial decisions on behalf of the beneficiary, the representation does not become invalid upon the beneficiary's subsequent incapacitation.

NOTE: Some durable powers of attorney do not become effective until and unless such an incapacitation occurs.

If the beneficiary is deceased, the request may be filed by the legal representative of the estate. In the absence of a legal representative, it may be filed by any person who has assumed responsibility for settling the decedent's estate. In these situations, you must obtain proof that the person has assumed responsibility for settling the decedent's estate (e.g., a will or probate court document). What is acceptable as legal documentation may vary according to State law. In such instances, document the file to show the basis for that person's filing the appeal. (See 42 CFR Part 424, Subpart C - Claims for Payment and 42 CFR Part 424, Subpart D - To Whom Payment is Ordinarily Made.)

12004.11 Disclosure of Individually Identifiable Beneficiary Information to Representatives.--In accordance with the provisions of the Privacy Act, prior to releasing beneficiary-specific information to a representative, the beneficiary must (1) complete and sign an appointment of representative form naming that individual as his/her representative, or (2) complete and sign an authorization form explicitly allowing the release of his/her information to the representative.

In general, you should not release a beneficiary's information without the beneficiary's explicit written authorizations. (For more information about the disclosure of information about identifiable beneficiaries, see MCM, Part 3, §§10010-10037 and 12011 below.)

12006. AMOUNT IN CONTROVERSY

12006.1 Defined.--The dollar amount at issue that must remain to establish the right to a particular level of appeal. The amount in controversy requirements are established by Congress. (See 42 CFR §405.815 - Amount in controversy for carrier hearing, ALJ hearing and judicial review and 42 CFR §405.817 - Principles for determining amount in controversy.)

12006.2 General Requirements.--There is no minimum amount in controversy requirement for a review. For a HO hearing, at least $100 must remain in controversy following the review determination; for an ALJ hearing for Medicare Part B claim(s), at least $500 ($100 or more in the case of home health services); there is no amount in controversy required for DAB review; and for judicial review, at least $1,000 must remain in controversy. (See 42 CFR §405.815 - Amount in controversy for HO hearing, ALJ hearing and judicial review.)

Payments made under the limitation on liability provisions (§1879 of the Act) do not reduce the amount in controversy. In other words, the amount in controversy is calculated without regard to payment that was made for the denied item or service under the limitation on liability provisions.

12006.3 Calculating the Amount in Controversy.--The amount in controversy is computed as the actual amount charged the beneficiary for the item(s) and/or service(s) being appealed, less any allowed amount and less any deductible and coinsurance amounts applicable to the particular claim or claims involved. The decision about whether the amount in controversy requirement has been met is made by the HO at the HO level, and by the ALJ at the ALJ level. (See 42 CFR §405.817 - Principles for determining amount in controversy.)

A. General Calculation.--

Step 1:

Total amount charged for items/services in dispute
- Total amount allowed for items/services in dispute
Difference

Step 2:

Difference (from Step 1)
- Unmet deductible
Balance

NOTES: The Balance in Step 2 is the amount that remains in controversy if the services are not subject to coinsurance. For services subject to coinsurance, proceed to Step 3. Unmet deductible refers to any unmet Part B blood deductible, if applicable, as well as the routine Part B cash deductible.

Step 3:

Balance (from Step 2)
X .80 (80%)
Amount that remains in Controversy, for services subject to coinsurance.

B. Calculating the Amount in Controversy for Overpayments.--The amount in controversy for an overpayment is the actual amount of the overpayment contained in the demand letter. This amount is not subject to reduction due to coinsurance and deductibles that have already been paid.

C. Exclusions.--Calculation of the amount in controversy may take into account only those claims and items/services that are part of the review decision. The HO may not consider claims included in a later appeal request, except in cases of aggregation of claims, discussed below.

12006.4 Additional Considerations for Calculation of the Amount in Controversy.--A request for a HO hearing may include multiple claims. Where the HO issues a single decision involving more than one claim, extra care must be used in calculating and stating the amount in controversy as a result of the HO's decision:

- If the appeal involves claims that were previously denied and are now found to be covered/medically reasonable and necessary, the HO's decision should use language along the following lines:

As indicated above, the following claims will be paid by Medicare (indicate claim control number(s) or dates of service): _____. You will be notified of the specific payment amount separately. The following claims will not be paid by Medicare (indicate claim control number(s) or dates of service):_____. The amount that remains in controversy for these claims is **$_____.** (Add routine language regarding aggregation, where appropriate.) (See below.)

NOTE: The language in the above bullet will need to be modified if coverage is at issue for some of the claims involved in the appeal while the amount of payment is at issue for other claims involved in the appeal.

- If the appeal involves the amount that Medicare will pay for the item(s) or service(s), the HO determines the amount in controversy based upon all of the claims on appeal, indicating those claims where the payment amount was changed by the HO's decision. All claims will have an amount in controversy unless payment has been approved at the billed amount.

12006.5 Aggregation of Claims to Meet the Amount in Controversy.--Under the aggregation rules contained in 42 CFR §405.815, claims may be combined to meet the amount in controversy requirements. The calculation is the same as that discussed above in §12006.3--Calculating the Amount in Controversy. The decision about whether the amount in controversy requirement has been met is made by the HO at the HO level, and by the ALJ at the ALJ level. (See 42 CFR §405.817 - Principles for determining amount in controversy.)

A. The Appeal Request.--When requesting an HO or ALJ hearing, the appellant MUST clearly state that he/she is aggregating claims to meet the amount in controversy requirement AND the appellant must specify in his/her appeal request the specific claims that are being aggregated. (See 42 CFR §405.817(5) - Principles for determining amount in controversy.) You must notify appellants of this requirement as part of the appeals language advising them of aggregation rights on the review determination and HO hearing decision. If an appellant's request for HO hearing does not specifically state that the claims are being aggregated, or does not list the specific claims that are being aggregated, treat each claim as an individual request for HO hearing, dismissing those that do not meet the amount in controversy. Where the appellant is a beneficiary, use your discretion to accept implied requests for aggregation of claims to meet the amount in controversy. If you are not sure if aggregation is intended, make an effort to contact the beneficiary to determine his/her intent.

B. Handling Aggregated Claims at HO Hearing.--The regulations do not require that claims that were aggregated for the purpose of meeting the amount in controversy requirement be addressed in a single HO hearing and/or a single HO hearing decision. In other words, although a party may choose to aggregate claims to meet the amount in controversy requirement for the HO hearing level, the HO may hold separate hearings, and may issue separate hearing decisions, as appropriate. For example, it would be appropriate for claims that are aggregated by one physician/supplier and which include multiple beneficiaries and unrelated issues to be separated. However, in most cases, the hearing should be completed the way it comes to the HO.

C. Aggregation Rules at HO Hearing.--Two or more claims may be combined by an individual appellant (i.e., either a beneficiary, or a physician or other supplier with appeal rights) to meet the amount in controversy requirement at the HO hearing level IF each claim has had a review determination issued (or a revised initial determination, or a revised review determination) AND the request for HO hearing is timely-filed for all of the claims included in the aggregation request. The decision about whether or not the aggregation requirements have been met is made by the HO.

D. Aggregation Rules at ALJ Hearing.--A party may aggregate claims to meet the amount in controversy requirement for an ALJ hearing in one or more of the following ways:

- Two or more claims may be combined by an individual appellant (i.e., either a beneficiary, or a physician or other supplier with appeal rights) to meet the amount in controversy requirement IF each claim has had an HO hearing decision issued AND the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request;

- Two or more beneficiaries may combine their claims for services received from either the same or different physician or supplier IF the claims involve common issues of law and fact , AND each of the claims has had an HO hearing decision issued AND the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request;

- Two or more physicians or other suppliers with appeal rights may combine claims IF the claims involve the delivery of similar or related services to the same beneficiary AND each of the claims has had an HO hearing decision issued AND the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request; or,

- Two or more physicians or other suppliers with appeal rights may combine their claims IF the claims involve common issues of law and fact for services furnished to two or more beneficiaries AND each of the claims has had an HO hearing decision issued AND the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request.

At the ALJ level of appeal, it is the ALJ who is responsible for deciding whether the aggregation requirements have been met, including determining what constitutes common issues of law and fact and what constitutes similar or related services.

12008. EXTENSION OF TIME LIMIT FOR FILING A REQUEST FOR REVIEW OR HEARING OFFICER (HO) HEARING

The time limit for filing a request for review or HO hearing may be extended in certain situations. Generally, physicians or other suppliers are expected to file appeal requests on a timely basis. A request from a physician or other supplier to extend the period for filing the request for review or HO hearing should not be routinely granted and such requests warrant careful examination. For a beneficiary request, more leniency should be given.

Upon request by the party that has missed the filing deadline, you or the HO may extend the period for filing the request for review or HO hearing. The procedures for finding good cause to excuse late filing are discussed below.

NOTE: Good cause should not be considered over the phone and is not applicable for telephone reviews.

12008.1 Good Cause.--If an appeal request is filed late, you or the HO may extend the time limit for filing an appeal if good cause is shown. (See §12008.3--Conditions that May Establish Good Cause for Late Filing by Beneficiaries, and §12008.5--Conditions that May Establish Good Case for Late Filing for Physicians or Other Suppliers.) Resolve the issue of whether good cause exists before taking any other action on the appeal.

NOTE: A finding by you that good cause exists for late filing for the review does not mean that the party is then excused from the timely filing rules for the HO hearing.

12008.2 General Procedure to Establish Good Cause.--For a request for review or HO hearing that is not timely filed, and which contains sufficient evidence or other documentation that supports a finding of good cause for late filing, make a favorable good cause determination. Document the good cause determination in the appeals case file. Note the following items: the date the appeal request was received, the last date on which the appeal request could have been timely filed, the evidence that was submitted to support the finding of good cause for untimely filing, and the favorable determination. If you or the HO make a favorable good cause determination, consider the appeal to be timely filed and proceed with conducting the review or HO hearing.

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 or no other evidence that establishes the reason for late filing, explain in the dismissal letter that the beneficiary can show that good cause exists for late filing, that he/she may forward the explanation to you within 6 months from the date of your mailing of the notice of dismissal. If an explanation or other evidence is then submitted that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, make a favorable good cause determination. Once a favorable good cause determination has been made, consider the appeal to be timely filed and proceed with conducting the review or HO hearing.

The closed date is the date of the dismissal, and the dismissal is reported on the Carrier Appeals Report (Form CMS-2590). If you dismiss and then later find good cause, back the dismissal out of workload and count the completed review only.

B. Establishing Good Cause For Physicians or Other Suppliers When Insufficient Evidence/Documentation was Submitted.--When a physician or other supplier has failed to establish that good cause for late filing of an appeal request exists, dismiss the appeal request as untimely filed. Explain in the dismissal letter that if the physician or other supplier can provide additional evidence or documentation that good cause for late filing exists, then he/she must submit the evidence within 6 months from the date of your mailing of the notice of dismissal.

If the physician or other supplier submits evidence to you within 6 months of your dismissal that supports a finding of good cause for late filing, make a favorable good cause determination. However, for late filings of physicians or other suppliers, you should not routinely find good cause. If you or the HO make a favorable good cause determination, consider the appeal to be timely filed and proceed with conducting the review or HO hearing. If you or the HO do not find good cause, the dismissal remains in effect. There is no appeal of a finding that good cause was not established.

The closed date is the date of the dismissal, and the dismissal is reported on the Carrier Appeals Report (Form CMS-2590). If you dismiss and then later find good cause, back the dismissal out of workload and count the completed review only.

12008.3 Conditions that May Establish Good Cause for Late Filing by Beneficiaries.--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 (e.g., beneficiary does not speak or read English or Spanish; although you wouldn't find good cause in those cases where an individual speaks and reads Spanish and receives a Spanish EOMB/MSN, you would find good cause where a Spanish-speaking beneficiary does not read Spanish);

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, you, an intermediary, or the Social Security Administration) to the beneficiary (e.g., a party is not notified of her appeal rights or of the time limits for filing);

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; or

- Unusual or unavoidable circumstances, the nature of which demonstrate that the beneficiary could not reasonably be expected to have been aware of the need to file timely.

12008.4 Examples of Situations Where Good Cause for Late Filing Exists for Beneficiaries.--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 review or HO hearing.

- The request was received after, but close to, the last day to file, and the beneficiary claims that the request was submitted timely.

12008.5 Conditions that May Establish Good Cause for Late Filing by Physicians or Other Suppliers.--Good cause may be found when the record clearly shows, or the physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, you, an intermediary, or the Social Security Administration) to the physician or other supplier; or,

- Unavoidable circumstances that prevented the physician or other supplier from timely filing a request for review or HO hearing. Unavoidable circumstances encompasses situations that are beyond the physicians or suppliers control, such as major floods, fires, tornados, and other natural catastrophes.

NOTE: Failure of a billing company or other consultant (that the physician or other supplier has retained) to timely submit appeals or other information is NOT grounds for finding good cause for late filing. Do not find good cause where the physician or other supplier claims that lack of business office management skills or expertise caused the late filing.

12008.6 Examples of Situations Where Good Cause for Late Filing Exists for Physician or Other Suppliers.--Following are a few examples of cases where good cause for late filing may be found.

This list is not all inclusive:

- A fire destroys the physician's records.

- A flood closes a supplier's office for an extended period of time, or such other natural catastrophe.

12008.7 Good Cause Not Found for Beneficiary, or for Physician or Other Supplier.--When a request for extension of time limit for filing a request for review or HO hearing is not granted, you must advise the beneficiary, or physician or other supplier. Send a written notice stating that the request for extension has been denied, that the request for review or HO hearing has been dismissed, if not previously dismissed, and provide the reason why good cause was not found. Advise the party whose request you have dismissed that they may not appeal your determination as to whether good cause for late filing exists.

NOTE: If the HO does not find good cause for late filing, he/she may refer it to you to consider reopening. Also, if you do not find good cause for the late filing of a request for review, you may examine the case to determine whether you have any basis for reopening and revising your determination under your reopening authority.

12009. FRAUD AND ABUSE

12009.1 Authority.--To protect the Medicare program from fraud and abuse, civil and criminal violation provisions have been included in §§1107, 1128A, 1128B, 1872, and 1877 of the Act.

12009.2 Inclusion and Consideration of Evidence of Fraud and/or Abuse.--You and the HO should inquire fully into the matters at issue by receiving, in evidence, the testimony of witnesses and any documents that are relevant to the claims at issue. If you or the HO believes that evidence has been tampered with you should refer this documentation to either the medical review or fraud and abuse units for their follow-up.

You or the HO may receive evidence obtained and provided by the fraud unit concerning fraud or potential fraud with respect to the claim(s) at issue. If such evidence is provided by the fraud unit, it becomes part of the case file and must be made available for inspection by the appellant prior to the hearing. Evidence of this character is to be evaluated to determine issues such as whether, in conjunction with other credible evidence, the services in question were actually provided or were provided as billed.

12009.3 Claims Where There Is Evidence that Items or Services Were Not Furnished, or Were Not Furnished as Billed.--Where there is a substantial basis for determining that an item or service either was not furnished or was not furnished as billed, you may deny or downcode payment, as appropriate. The reviewer or HO must ensure that the case file clearly documents the evidence that formed the basis for the determination. Appeal rights after such a determination remain the same as they would for any other unfavorable decision.

If you or the HO has reason to believe or evidence to support that items or services were not furnished or were not furnished as billed, you should send a copy of the decision to your fraud unit.

12009.4 Responsibilities of Reviewers and Hearing Officers.--If, during the course of the review or HO hearing, the reviewer or HO suspects a civil or criminal law violation, he/she must render a decision only on the coverage or payment issues raised by the review or hearing request. Although the reviewer or HO cannot make a determination of civil or criminal fraud, they may still deny or reduce payment if he/she believes that the items or services at issue were not rendered, or were not rendered as billed (as discussed above). In making this determination the reviewer or HO may consider all available evidence, including witness testimony, medical records and evidence compiled through a fraud investigation, as discussed above. (See §12012.4(B)--Development of Appeal Case File and §12016.6(A)--Coordination with Other Areas, below.)

In addition to denying the claims because the services were not rendered as billed, if the reviewer or HO suspects fraud, he/she must forward information regarding the potential civil or criminal violation to the fraud unit. For further discussion on the Medicare fraud units, see MCM sections on Suspension of Payment and Overpayment Recovery.

12009.5 Requests to Suspend the Appeals Process.--Neither you nor the HO has the authority to suspend reviews or HO hearings at the request of the Office of the Inspector General (OIG) or the Department of Justice (DOJ) without approval and direction from CMS CO. If you receive a request from the OIG or DOJ to suspend a review or hearing, bring that request to the attention of CMS CO through your RO.

12009.6 Continuing Appeals of Physicians or Other Suppliers Who are Under Fraud or Abuse Investigations.--Reviewers and HOs must continue adjudicating the appeals of Medicare claims submitted by a physician or other supplier who is being or has been investigated, indicted, or convicted for fraud or abuse on other Medicare claims, or who is on Medicare payment suspension, unless you have been informed that the physician or other supplier has agreed, as part of a settlement with the Government, or as the result of a prosecution, to withdraw the appealed claims or to waive the right to appeal the subject claim(s). If you have received notice of such a settlement, you shall dismiss the appeal based on the fact that the appellant has waived his or her right to an appeal, and/or agreed to withdraw the appeal of these claims as part of a settlement agreement with the Government. Place a copy of the settlement document or other evidence of a settlement in the file. A reviewer and the HO must remain neutral in the adjudication of claims that involve a physician or other supplier who is being or has been investigated, indicted, or convicted of fraud or abuse.

12009.7 Appeals of Claims Involving Excluded Physicians or Other Suppliers.--The appeals process remains in effect for all claims with service dates prior to the effective date of exclusion, and any appeal rights of an excluded physician or other supplier may be exercised following the normal administrative appeals process.

The appeal rights of a beneficiary are present for all claims with service dates prior to the effective date of the exclusion, as well as for some claims with service dates after the date of exclusion.

12010. GUIDELINES FOR WRITING APPEALS CORRESPONDENCE

The guidelines in this section are to be used when preparing appeals correspondence, including review determinations and HO hearing decisions and inquiries about the status of appeals. These must be handled as expeditiously as possible without lowering the quality of the response. General instructions on responding to beneficiary and provider communications are found at MCM, Part 2 - §§5104, 5105, and 5106. All other CMS-issued instructions on correspondence guidelines apply as well, including instructions on correspondence letterhead requirements.

12010.1 General Guidelines.--You should prepare appeals correspondence so that the appellant can easily understand both the reason why any of the services were not covered or could not be fully reimbursed, and what action the appellant can take if he/she disagrees with that decision. The unique paragraphs of the appeals correspondence may be written at a comprehension level equal to the comprehension level of the appellant's request for appeal. If you are in doubt as to the appellant's comprehension level, and the appellant is the beneficiary, write your correspondence below the eighth grade reading level.

In addition, the following guidelines should be followed to the extent possible:

- Keep the language as simple as possible.
- Do not use abbreviations or jargon.
- Choose a positive rather than a negative tone, whenever possible. Avoid words or phrases which emphasize what you or the appellant cannot do.
- If possible, avoid one sentence paragraphs, uneven spacing between paragraphs, etc.
- Apologize when appropriate, e.g., if the response is late. However, do not apologize for enforcing Medicare guidelines which may be adverse to the appellant's claim.
- Summarize the question before providing a response.

12010.2 Letter Format.--Appeals correspondence (including the review-telephone and written-determination and HO hearing decision) must follow the instructions issued by CMS for contractor written correspondence letterhead requirements unless otherwise instructed and/or agreed to by CMS.

In addition, note the following:

- Do not use numerical dates (i.e., instead of 6/16/98, use June 16, 1998).
- Do not use type/font size smaller than 12 point.

- Do not abbreviate names to fit within a given space on an automated letter (e.g., do not use: Comm. Mem. Gen. Hosp. for Community Memorial General Hospital).

- When the subject matter is lengthy or complicated, use bullet points to clarify.

- For long letters, use headings to break it up (e.g., DECISION, BACKGROUND, RATIONALE).

- If citing procedure codes, be sure to include the name of the actual procedure.

- Do not use span dates for one day of service.

- LETTERS THAT CONTAIN ALL CAPITAL LETTERS APPEAR IMPERSONAL AND COMPUTER GENERATED. DO NOT USE ALL CAPITAL LETTERS.

- You may produce separate determination or decision letters on multiple beneficiary requests, where the request has been split. This will enable you to provide each beneficiary with a copy of her/his determination or decision and to protect the privacy of each beneficiary.

12010.3 Required Elements in Appeals Correspondence.--Note the following:

- Use the name of the beneficiary/physician/supplier to whom the letter is addressed rather than "Dear Sir/Madam."

- Identify correspondence by either the date on the letter or the date the letter was received.

- Include the name of the physician or supplier as well as the date(s) of service.

- When appropriate, explain to beneficiaries why they are being sent a letter if the appeal came from the physician or other supplier.

- Put the appeal determination/decision in the beginning of the letter.

- Include in the determination/decision an explicit rationale that describes why the items or services at issue do not meet Medicare guidelines. (See §12019.7E for an example.) Merely stating that an item or service is "not medically reasonable and necessary under §1862(a)(1)" or "not medically reasonable and necessary under Medicare guidelines" is conclusive and does not provide any rationale. Rationale includes a description of the logic that led to the decision, references to the support for the basis of the decision, and other information that is relevant to support the decision in the case.

- When the appeals correspondence includes Medicare citations, relate applicable Medicare citations in layman's terms. List the cite as a parenthetical at the end of the sentence. For example, instead of beginning a sentence with, "§1879 of the Social Security Act states that...", you could begin the sentence with "Under Medicare law, suppliers must....(See §1879 of the Social Security Act)."

- Whenever the person is to receive some further response, such as an EOMB or an MSN, indicate an estimated time frame as to when he/she will receive it.

- Include a telephone number on all correspondence for additional questions.

- Always tell the reader what, if anything, needs to be done next.

- When appropriate, include the results of any consultations with professional medical staff.

- When applicable, include a statement advising the appellant that upon written request you will provide copies of regulations, statues, and guidelines used in making the determination.

- For appeals, if the determination is partially or wholly favorable include an explanation about why the new determination is different from the previous determination.

- Write the correspondence in a clear manner and with a customer-friendly tone.

12011. DISCLOSURE OF INFORMATION

12011.1 General Information.--The basis for policy governing the disclosure and confidentiality of information collected by you 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 MCM, §§10000 - 10099, for more information on disclosure of information.)

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 MCM sections on fraud and abuse.)

12011.2 Fraud and Abuse Investigations.--Any and all evidence used by you or the HO to arrive at a determination or decision must be placed in the appeals case file (copies are fine). Information in the case file must be made available to an appellant upon request. Therefore, your fraud unit must be aware that information placed in the case file is accessible to an appellant. The fraud unit should also understand that you and the HO may not consider any evidence that has not been made a part of the case file. Fraud units should therefore exercise discretion when deciding whether to place any of the following information into the appeals case file:

- The impetus behind a fraud and abuse investigation;
- The name of the beneficiary or any other person lodging the complaint that triggers the fraud and abuse investigation;
- Notes or transcripts of beneficiary interviews resulting from a fraud and abuse investigation;
- Records or information compiled for law enforcement purposes during a fraud and abuse investigation; or,
- The name of a confidential source(s) when confidentiality has been promised by CMS in return for cooperation in a fraud and abuse investigation.

Where you rely upon any of the above information in order to deny a claim or to render a less than fully favorable determination or decision, then an appellant has a due process right to review this information. If information is kept out of an appeals case file for confidentiality reasons, it may not be relied upon to deny or reduce payment.

12011.3 Medical Consultants Used.--The parties are entitled to know the identity and qualifications of any consultant whose evidence either you, or the HO, used to support the initial claim determination, the review determination, or the HO hearing decision. If you or the HO use a consultant, include the identity and qualifications in the file for possible use by the ALJ, and for the appellant's use upon request. This applies to both external medical consultants and internal staff used to review the claim. An example of this would be the name and title of the medical consultant.

12011.4 Multiple Beneficiaries.--If claims of more than one beneficiary are involved in the hearing, and each beneficiary is being sent a copy of the decision, the HO should ensure the privacy of each beneficiary's records. The decision letter may be issued for each beneficiary, or you may issue a basic decision letter, and include it with a cover letter to each beneficiary.

12012. REVIEW - THE FIRST LEVEL OF APPEAL

A party dissatisfied with your initial determination may request by telephone or in writing that you review your determination. (See 42 CFR §405.807(b) - Place and method of filing a request.) A review is the first level of appeal after the initial determination on a Part B claim. It is a second look at the claim and supporting documentation and is made by a different employee. If an initial determination on a claim has not been made, there are no appeal rights on that claim, except in one limited circumstance. (See §12014.4.A. - Claim for Payment not Acted Upon with Reasonable Promptness.)

The reviewer must comply with, and is bound by, all applicable statutory and regulatory provisions. The reviewer may not overrule the provisions of the law or interpret them in a way different than CMS does; nor may the reviewer comment upon the legality, constitutional or otherwise, of any provision of the Act, regulations or CMS policy in the review determination. The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, program memoranda, national coverage determinations, carrier-issued local medical review policies (LMRP) and regional medical review policies (RMRP). The reviewer must consider the applicability of all CMS-issued policies and procedures (including LMRP and RMRP) to the facts of a given claim. The reviewer may not disregard or override an applicable LMRP or RMRP, nor may the reviewer change the amount required to be paid under the Physician Fee Schedule.

12012.1 Filing a Request for Review.--A request for review can be filed with you in writing or by telephone. A written request may also be filed with CMS, the Railroad Retirement Board (RRB) for RRB retirees, or SSA. A telephone request may be made by telephone to the number designated by you for receipt of requests for review. The request may be made by a party to the appeal as defined in §12002 and/or the party's representative as defined in §12004. Also, for beneficiaries there are special rules described below in (A).

A. Written Review Requests Filed on Behalf of the Beneficiary.--A written request for review may be submitted by someone other than an appointed representative on behalf of a beneficiary. Honor the request for review if the request clearly shows the beneficiary knew of or approved the submission of the request for review (e.g., the request is submitted with a written authorization from the beneficiary or with the beneficiary's EOMB/MSN). However, if you have information that the appointment was not submitted at the request of the beneficiary, do not conduct the review unless and/or until you receive confirmation from the beneficiary that the request was submitted with his/her approval. 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 §12004.8(A)(1) for instructions on developing an incomplete or absent appointment of representative.) In cases of reviews filed on behalf of the beneficiary, you do not need to develop an absent appointment of representative if the request for review clearly shows the beneficiary knew of or approved the submission of the request for review. However, you may send the individual filing on behalf of the beneficiary a notice including information on how to become a representative of the beneficiary and what he/she should know if he/she fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, he/she will not be the official representative, etc.).

Persons who often act on behalf of a beneficiary in filing a review request include: the spouse, parent, daughter or son, sister or brother, or neighbor/friend. Beneficiary advocacy groups and Members of Congress may also submit a request for review on behalf of a beneficiary. (See below for further discussion on requests submitted by Members of Congress.) Even though the review request is made on behalf of a beneficiary by someone other than his/her appointed representative, all written notices related to the appeal must be sent only to the beneficiary, not the individual making the request for review.

Although you may have honored a request for review filed by someone other than the beneficiary or his/her appointed representative, only the beneficiary or representative should be contacted or consulted for further information when processing the review and when issuing your determination (unless the requestor is the beneficiary's legal guardian, in which case no appointment is required).

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, you may decide to allow the person submitting the request for review to act on behalf of a beneficiary who is mentally or physically incapacitated. Your decision, as well as the beneficiary's incapacitation, should be documented in the file and supported by relevant medical documentation. (See MCM, §§12004.9 and 12004.10, for more information on this subject.)

1. Requests for Review Submitted by Members of Congress.--When you have honored a request for review filed by a Member of Congress pursuant to a Congressional inquiry made on behalf of a beneficiary or physician or other supplier, you may continue to provide a 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, but does not include release of personal information about a beneficiary that the Member of Congress did not already have in his/her possession. If the Member of Congress expresses an interest in acting as the representative of a beneficiary or of a physician or other supplier, the party must complete an appointment of representative form or written statement.

B. What Constitutes a Request for Review.--

1. Written Requests for Review Made by Beneficiaries.--Beneficiaries may request a review in writing by filing a completed Form CMS-1964. Beneficiaries may also request a review in writing instead of using the form. Requests for review may be submitted in situations where beneficiaries assume that they will receive a review by questioning a payment detail of the determination or by sending additional information back with the EOMB/MSN, but don't actually say: I want a review. For example, an inquiry (either written or verbal) stating, "Why did you only pay $10.00?" should be considered a request for review. Further, if the beneficiary calls it a "reopening" or asks you to reopen your decision, but it is submitted within the time limit for filing a request for review, consider this a request for review.

Common examples of phrasing in letters from beneficiaries that constitute requests for review:

- 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.

Or 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 Review Submitted by a State, Physician or Other Supplier.--States, physicians or other suppliers with appeal rights must either submit written requests indicating what they are appealing and why. There are two acceptable written ways of doing this:

a. A completed Form CMS-1964 constitutes a request for review. Supply these forms upon request by an appellant. (See Exhibit 2 for a copy of a Form CMS-1964, Request for Review of Part B Medicare Claim.) Completed means that all applicable spaces are filled out and all necessary attachments are attached.

b. A written request for appeal not on Form CMS-1964, but containing 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);
- Which item(s), if any, and/or service(s) are at issue in the appeal; and
- Signature of the appellant.

NOTE: Some review requests may contain attachments. For example, if the RA is attached to the review 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 review request.

Frequently, a party will write to you concerning the initial determination instead of filing Form CMS-1964. How to handle such letters depends upon their content and/or wording. A letter serves as a request for review if it contains the information listed above and either (1) explicitly asks you to take further action or (2) it indicates dissatisfaction with your decision. Count the receipt and processing of the letter as an appeal only if you treat it as a request for review. You must note the details of your actions (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

If any of this information is not included within the appeal request, return it to the State or provider with an explanation of what information must be included. (For a complete discussion of inquiries, see MCM, Part 2 - Program Administration, §§5104, 5105, and 5106.)

3. Letters and Calls That are Considered Inquiries.--Consider 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;
- It is a status request. State in your reply that you are responding to a status request, do not use the word "review" in your reply;
- It is a request for information; or
- The party asks only for a second copy of a notice.

4. Telephone Requests for Review from Beneficiaries.--Beneficiaries may request a review by telephone at a number designated by you for receipt of review requests. Follow instructions above in (1) for what to consider a request for review. Although the beneficiary may request that you perform the review by telephone, you make the decision as to whether or not the review should be conducted over the telephone. (See §12013 for more information on telephone reviews.)

5. Telephone Requests for Review from a State, Physician or other Supplier.--States, physicians or other suppliers with appeal rights may request a review by the telephone at a number designated by you for receipt of review requests. Although a State, physician, or supplier may request that you perform the review by telephone, you make the decision as to whether or not the review should be conducted over the telephone. (See §12013 for more information on telephone reviews.)

The appellant must provide the following information at the beginning of the phone call in order to request a review:

- Beneficiary Name;
- Beneficiary Date of Birth;
- 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.

12012.2 Time Limit for Filing a Request for Review.--A party must file a request for review within 6 months of the date of the initial determination as indicated on the EOMB/MSN or RA. The date of filing for requests filed in writing is defined as the date received by you in the corporate mailroom minus 5 days to allow for normal mail delivery time. (For example, if your receive a request for review in the corporate mailroom on August 10, you subtract 5 days from the date

received. In this case, the date of filing is August 5.) If the party has filed the request in person with either you, CMS, or SSA, or with the RRB for RRB beneficiaries, it 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 review to a CMS, SSA, or RRB office, the date of filing is the postmarked date on that envelope. The date of filing for telephone requests for review is defined as the date the phone call is received.

You may extend the period for filing if you find the appellant had good cause for not requesting the review timely. (See §12008 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing. If you find that the appellant did not have good cause for not requesting a review on time, you may at your discretion consider reopening. (See §12100 -- Reopening and Revision of Claims Determinations and Decisions.)

12012.3 Recording of Inquiries and Other Actions on the Carrier Appeal Report (Form CMS-2590).--Do not record written or telephone inquiries as requests for review unless they contain stated requests for review as explained above. Where a request is recorded as an appeal, do not also record that request as an inquiry.

12012.4 The Review.--The review is an independent, critical examination of the claim made by carrier personnel not involved in the initial claim determination. In performing a review of the services requested by the appellant, carrier personnel must examine all issues in the claim.

A. Timely Processing Requirements.--You must complete 95 percent of requests for review within 45 days of receipt of the request. The date of receipt for purposes of this standard is defined as the date the request for review is received in the corporate mailroom for written requests and as the date the request was received on the telephone for telephone requests. Completion is defined as when the final determination (EOMB/MSN, RA, or other notice-including dismissal) is printed and released or upon notification of withdrawal by the appellant. In the case of a reversal, consider the case completed when you initiate the adjustment action. (See MCM, §13400.)

For reviews conducted on the telephone (see §12013 for a discussion of telephone reviews), the date the telephone review is completed is defined as when the final determination is printed and released (most telephone reviews should be adjudicated the same day as received on the phone; however it may take a few days to complete the written determination). In the case of a reversal, consider the case completed when you initiate the adjustment action.

B. Development of Appeal Case File.--The reviewer must secure and review all available, relevant information needed to make his/her determination. Other areas within the carrier may have information relevant to the claim(s) at issue. For example, the program integrity area (including medical review, overpayments, and fraud and abuse) may submit evidence to you for inclusion in the case file. Such evidence must be made available for inspection by an appellant upon request. Reviewers must exercise care in determining the weight to give fraud and abuse information 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 denial of the claim(s). (See subsection D., below, for instructions on development of documentation.)

C. Elements of the Review.--The following elements are essential to performing an adequate review:

- The reviewer must not be the same person who made the initial determination.

- How you conduct your review depends on the appellant's request and what is at issue. There may be times where the appellant requests a review of an entire claim and there may be times where he/she requests a review of a specific line item on the claim. You 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 reasonable charge, also review medical necessity, coverage, deductible, and limitation on liability, if applicable.

If the appellant requests a review of a specific line item, review all aspects of the claim related to that line item. If appropriate, review the entire claim. If you review more than what the appellant indicated, include an explanation in the rationale portion of the review determination letter of why the other service(s)/item(s) were reviewed.

For appeals of a specific line item or service, the initial determination is the date of the first EOMB/MSN or RA that states the decision. Adjustments to the claim that are included on later copies of the EOMB/MSN or RA do not extend/change the appeal rights given under the initial determination. All other line items not yet reviewed may be reviewed within 6 months from the initial determination, if requested.

- Although the reviewer may not make a finding of criminal or civil fraud (see §12009, 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.

- Appellants must have the opportunity to submit written evidence and arguments relating to the claim at issue. This does not mean you must request such material, but you must accept and consider any relevant documentation submitted.

D. Requests for Documentation.--You should not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, 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 physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, advise the physician or other supplier to submit the required documentation. Notify them of the timeframe they have to submit the documentation. Document your request in the review case file. The requested documents may be submitted to you via facsimile, at your discretion. In rare cases, a physician or other supplier might inform you that he/she is having trouble obtaining the supporting documentation, such as hospital records. In this situation you may provide the physician or other supplier with assistance in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, conduct the review based on the information in the file. You must consider evidence that is received after the 14-day deadline but before you have made and issued your review determination. The same standards apply for requests for review made over the telephone.

For beneficiary-initiated appeals, notify the beneficiary (either in writing or via a telephone call) when you have asked his/her physician or other supplier for additional documentation. Advise the beneficiary (either in the letter or during a telephone call) that the physician or other supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, you will decide based on the evidence in the case file. If you send the beneficiary a letter, also include a description of what kind of documentation you have requested.

Continue to routinely include instructions on the appropriate information to submit with appeal requests in your provider newsletters and other educational literature. Physicians and other suppliers are responsible for providing all the information required by you in order to adjudicate the claim (s) at issue. Although physicians and other suppliers are to provide all necessary documentation when filing the claim, if he/she fails to provide documentation at the initial determination and then appeals your initial determination, he/she should provide all relevant information and documentation at the time the appeal is requested.

12012.5 The Review Determination.--Send the review determination to the appellant and copies to each party and authorized representative (as applicable) if the determination is either partially or wholly unfavorable.

A. Calculating the Amount in Controversy.--For all claims where the prior denial is upheld, you must include in the determination letter the amount that remains in controversy for each claim. (See §12006 - Amount in Controversy.) This is necessary as the beneficiary will not be receiving an EOMB or MSN, and the physician or other supplier will not be receiving a RA. Without this information, it may be difficult for a beneficiary or other party to the appeal to determine which claims he/she would need to aggregate in order to meet the amount in controversy requirements for the next level of appeal.

B. Favorable Determinations.--If the determination is a full reversal (i.e., is fully favorable meaning the total amount in controversy is payable), send all parties and appointed representatives an adjusted EOMB/MSN or RA. You should not issue a review determination letter. The EOMB/MSN provides the beneficiary with information as to their financial liability with regard to the claim(s) that are now payable.

If the determination is a partial reversal (i.e., the total amount in controversy is not payable), send all parties and appointed representative an adjusted EOMB/MSN or RA and a review determination letter including your rationale for your decision.

C. Determinations that Result in Refund Requirements.--If as the result of a denial a physician or other supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then you must send a copy of the adjusted RA in the following situations:

1. A nonparticipating physician not accepting assignment who, based on the review determination, 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.

D. Dismissals of Review Requests.--You may dismiss a request for a review under the following circumstances:

1. Request of Party.--A request for review may be withdrawn at any time prior to the mailing of the review decision upon the request of the party or parties filing the request for review. A party may request a dismissal by filing a written notice of such request with you or by orally stating such request during a telephone review. This dismissal of a request for review is binding unless vacated by you.

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

- Where the party requesting a review is not a proper party or does not otherwise have a right to a review; or

- Where the party who filed the review request dies and there is no information showing that an individual who is not a party may be prejudiced by your initial determination.

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

4. Appointment of Representative is Incomplete or Absent.--When an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment and the appointment is not corrected within the time limit discussed above in §12004.8(A)(2) or when the individual fails to include an appointment with the appeal request, you should dismiss the request.

NOTE: Do not count duplicate review requests or review requests received before you have made an initial determination on a claim. (See MCM, §13410.2.)

You must issue a written notice of dismissal to all parties to the appeal. You must include in the notice the information that, at the request of a party and for good and sufficient cause shown, you may vacate your dismissal of a request for review at any time within 6 months from the date of your mailing of the notice of dismissal. The dismissal notice is sent to the party requesting the review at his/her last known address, as well as to his/her representative. The dismissal notice includes the reason for the dismissal.

12012.6 Review Determination Letter.--

A. Review Determination Format and Standard Language.--Use the following review determination format or something similar and standard language paragraphs. Both the guidelines and fill-in-the-blank information (specific to each review determination) are in brackets ([ ]); the fill-in-the-blank information is also underlined. The bullet items are included in the body of the review determination letter to assist you with developing the letter, but should not be included in the actual letters sent out.

B. Review Determination Letterhead.--The review determination letterhead must follow the instructions issued by CMS for contractor written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

MODEL REVIEW DETERMINATION FORMAT AND STANDARD PARAGRAPHS.--

CMS alpha representation

MEDICARE
PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

THIS IS YOUR MEDICARE PART B REVIEW DETERMINATION

Date

Appellant's Name
Appellant's Address
Appellant's Party Status (either beneficiary, physician, or supplier)

RE:
Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Physician/Supplier Name:
Date(s) of service:
Type(s) of Service:

NOTE: Use one of the following two statements:

This decision is **PARTIALLY FAVORABLE to you**. You will receive a(n) [Explanation of Your Medicare Part B Benefits/Medicare Summary Notice/Remittance Advice] within [estimated time frame]. Please see instructions below if you disagree with this determination. The amount in controversy is _____. [Include statement of financial liability of the beneficiary in beneficiary letter or copy.]

OR

This decision is **UNFAVORABLE to you.** Please see instructions below if you disagree with this determination. The amount in controversy is _____. [Include statement of financial liability of the beneficiary in beneficiary letter or copy.]

Dear [Name of Party that Appealed]:

We are in receipt of your request for review dated [either the date on the review request or, if request wasn't dated, the date the request was received]. As you have asked, we have made a new and independent review of the above claim(s). The person doing the review did not take part in making the initial determination.

- BACKGROUND INFORMATION PARAGRAPH: 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.

- RATIONALE PARAGRAPH: This is the most important element of the review. 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 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 requirements for this paragraph.

- FINANCIAL PROTECTIONS PARAGRAPH: Include information on limitation on liability, waiver of recovery, and physician/supplier refund requirements, as applicable. (See §7100ff for further discussion of waiver of recovery of an overpayment under §1870 of the Act. See §7300ff for further discussion of limitation on liability under §1879 of the Act. See §§7300ff and 7500ff for further discussion of physician refund requirements under §1842(l)(1) of the Act, and see §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act for supplier refund requirements.)

FURTHER APPEAL RIGHTS: HEARING OFFICER HEARING

If you are dissatisfied with this review determination, you may be able to appeal this review to the next level of appeal, known as the Hearing Officer hearing.

The law requires that at least $100 remain in controversy for you to request a Hearing Officer hearing, that your request for Hearing Officer hearing be filed within 6 months of the date on this review determination, AND, that your request must be made in writing.

If less than $100 remains in controversy, you may combine the claim or claims that are the subject of this review determination with claims from other recently issued review determinations you have received (or may receive) to meet the $100 amount remaining in controversy requirement. This is called "Aggregating Claims" and more information is provided below.

You or your authorized representative (if you have appointed a representative) should write to the address below to request a Hearing Officer hearing.

AGGREGATING CLAIMS:

To "aggregate claims" EACH CLAIM included in your request for Hearing Officer hearing must be appealed within 6 months from the date the review determination was issued on the claim, and each claim must have already received a review determination.

If you wish to request a Hearing Officer hearing by combining the amounts remaining in controversy from other claims, you MUST clearly state on your request for Hearing Officer hearing that you are "aggregating claims", AND you must list the specific claims that you are aggregating. The decision about whether or not the aggregation requirements have been met is made by the Hearing Officer. If you do not clearly state on your request for Hearing Officer hearing that you are aggregating claims, the Hearing Officer will have to treat each claim as an individual request for hearing, and will have to dismiss those claims that do not meet the amount in controversy.

A party may aggregate claims to meet the $100 amount remaining in controversy requirement for a Hearing Officer hearing in one of two ways:

1. An individual beneficiary may combine claims from two or more physicians or suppliers to meet the amount remaining in controversy requirement if each claim has had a review determination issued AND the request for Hearing Officer hearing is timely-filed for all of the claims included in the aggregation request; or,

2. An individual physician or supplier may combine claims from two or more beneficiaries to meet the amount remaining in controversy requirement if each claim has had a review determination issued AND the request for Hearing Officer hearing is timely-filed for all of the claims included in the aggregation request.

INFORMATION ON THE HEARING OFFICER HEARING LEVEL OF APPEAL:

If you request a Hearing Officer hearing, it will be held by an impartial Hearing Officer. You may send additional information along with your request for Hearing Officer hearing. There are three types of hearings available. Following your request for Hearing Officer hearing, you will be asked to select one of the following:

1. An On-the-Record hearing, where the Hearing Officer will make a decision based on the facts in the file and any additional information you submit;

2. A Telephone Hearing, where a Hearing Officer will contact you, and/or your representative (if you have one), to discuss your case over the phone; or

3. An In-Person hearing, where you and/or your representative will appear before the Hearing Officer to provide information.

You may appoint any individual, including an attorney, to act as your representative, and all the actions taken by your representative shall be on your behalf. In order to appoint a representative you must sign and complete an Appointment of Representative form, which you can obtain by calling the phone number provided on this review determination. If you choose to have a representative, please include his or her name, address, and telephone number in your Hearing Officer hearing request.

- PARAGRAPHS IF BENEFICIARY HAS A REPRESENTATIVE: Insert the following two paragraphs if the beneficiary has a representative.

APPOINTMENT OF REPRESENTATIVE:

You have appointed an individual to act as your representative. Your representative will receive a copy of this review determination and can assist you with an appeal if you wish to file one.

In addition, volunteers at Medicare peer counseling programs in your area can also help you. (See your Medicare Handbook under State Health Insurance Assistance Program for insurance counselors in your area.) If you would like more information on how to get in touch with a counselor, please call the phone number provided on this review determination.

- NO REPRESENTATIVE PARAGRAPHS: Insert the following two paragraphs if the beneficiary does not have 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. There are also groups, such as legal aid services, that will provide free advisory services if you qualify.

In addition, volunteers at Medicare peer counseling programs in your area can also help you. See your Medicare Handbook for Insurance Counselors in your area. If you would like more information on how to get in touch with a counselor, please call the phone number provided on this review determination.

- LAST PARAGRAPH: Finish the review determination letter with the following paragraph.

If you want copies of the statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, please let us know. Please attach a copy of this letter to your request. If you need more information or have any questions, please do not hesitate to call us at the phone number provided on this review determination.

Sincerely,

(Name of Individual)
(Title)

cc:
Representative (if applicable)
Physician/supplier (if appellant is the beneficiary and the physician/supplier has appeal rights or refund obligations)
Beneficiary (if appellant is the physician/supplier)

NOTE: You must protect the privacy of other beneficiaries if this case involves multiple beneficiaries.

12012.7 Effect of the Review Determination.--The review determination is binding upon all parties to the review unless either a HO hearing decision is issued or the review determination is reopened and revised in accordance with your reopening authority.

12013. TELEPHONE REVIEW PROCEDURES

A telephone review is a review that is requested on the telephone and also is performed entirely on the phone or through a follow up telephone call to the appellant. Telephone reviews are subsequently completed through a review determination letter or other notice. (See §§12012.5 and 12012.6 for information on review determination requirements.) Whether a request for review is made by telephone or is conducted and completed as a telephone review depends on the issues at hand and the complexity of the matters involved.

A party dissatisfied with your initial determination may request a review of your determination by telephone. For some of these requests, you may be able to perform the review on the telephone or through a follow-up call. Receiving review requests and conducting reviews on the telephone should expedite and simplify the review. For other requests made by telephone, you will need to transfer them to the appropriate department for written reviews. Requesting a review on the telephone provides quick and easy access to the appeals process for appellants.

You must have the capacity to take all requests for review on the telephone, however, you do not need to complete all reviews over the phone. Those review requests that cannot be handled over the phone must be transferred to the written review sections.

Ensure that the Privacy Act is applied to your telephone review process. All telephone reviewers must be trained on the Privacy Act requirements.

Apply the same standards to telephone reviews for how a review is conducted and what documentation is needed as you apply to written reviews.

12013.1 Informing the Beneficiary and Provider Communities About Your Telephone Review Process.--Inform beneficiaries, providers, physicians, and suppliers of your telephone review process 30 days prior to initiation and annually thereafter or when making significant changes to your process. Provide information about your process through means such as: bulletins/newsletters, newspaper articles, senior citizens groups, beneficiary outreach groups, customer service/inquiry departments, provider relations, seminars, etc.

Information you publish about your telephone review process should include:

- How to access the process (telephone number, hours of operation, etc.).
- Any limitations (such as certain issues, number of claims/issues per call, etc.).
- Specific instructions that the party must state that they are requesting a telephone review.
- Type of documentation that appellant should have on hand when calling in to request a review.
- How to submit additional documentation (fax, mail, etc.) and any timeframes.

- The types of issues you might be able to handle over the telephone and the types of issues you will not handle over the telephone. (**NOTE:** Issues that require input from other than the review analyst should not be handled over the telephone.)

- Appellants have 6 months after the date of the initial determination to request a review by telephone.

12013.2 Issues for Telephone Reviews.--Telephone reviews (requests for review where a decision can be rendered on the phone) should be limited to resolving minor issues and correcting errors. As with any appeal, telephone reviews are only applicable in situations where an initial determination has been made, claims that cannot be processed are not initial determinations and therefore are not appealable. (See MCM, §3005.)

At a minimum, you should be able to complete a review over the telephone of the following types of issues:

- Number of services/ units;
- Add, change or delete certain modifiers;
- ICD-9 Diagnosis codes;
- Erroneous denials (as duplicates);
- Procedure codes;
- Place of service; or
- Dates of service.

NOTE: As necessary, request providers to fax in the proof to support changes and error correction.

Telephone reviews are **generally inappropriate** for the following issues:

- Limitation of liability;
- Potential overpayments;
- Medical necessity denials and reductions; or
- Analysis of documents such as operative reports, clinical summaries.

NOTE: If you have tight management controls to handle these types of reviews, including a means of receiving all appropriate documentation to support conducting the appeal over the telephone, you may choose to handle some of these issues over the phone as appropriate. However, the more complicated the issue, the more important it is to have proper documentation in the file to support the decision.

In all cases, telephone reviews are **inappropriate** for the following issues:

- Claims requiring the input of medical staff or other entities outside of the review department such as provider enrollment, CWF, or CMS, etc.

- Provider number/ name.

NOTE: Even though telephone reviews are inappropriate for some issues you must be able to take requests for reviews on these issues over the telephone.

12013.3 Issues During the Telephone Review.--Whether or not you conduct a review on the telephone subsequent to a request for review made on the telephone depends on what is at issue. For example, an issue that requires a complex review must be accepted as a review request, however, you do not need to conduct the review on the telephone.

A. Issues that Cannot be Resolved During the Telephone Review.--There may be instances where an issue cannot be resolved during the telephone review. An issue may not be able to be resolved on the telephone because of the following reasons: (1) the issue becomes too complex to be handled over the telephone and/or it is in the best interest of the appellant to have a more in-depth review performed; or (2) there is a need for additional medical documentation from the physician and the information cannot be faxed in during the telephone review or within a reasonable time (48 hours or the equivalent of two full business days). (See §12012.4 (D) for information on requests for documentation that is needed to make a determination.)

If the issue cannot be resolved due to one of the preceding reasons, advise the appellant that review cannot be handled over the telephone. You will need to conduct the review in writing, however, the appellant does not need to submit his/her request in writing. Take the necessary steps to forward the request for review to the written appeals section. Give the appellant a confirmation/control number to confirm the request for review was made and was filed timely. Consider the date of the telephone call the date of the request for review. In order to expedite and make more efficient the transfer from the telephone review unit to the written review unit, you may wish to develop a form. Include this form in the case file.

B. Issues that Can be Resolved During the Telephone Review.--In situations when the necessary information/documentation can be faxed during or prior to the telephone review or within a reasonable time (48 hours or the equivalent of two full business days) and a decision can be made (the issue is not too complex to be handled over the telephone and/or the appellant does not need a more in-depth review to be performed), inform the appellant of your decision at the conclusion of the call or via a follow-up phone call. The date of your decision is considered the day of the requesting phone call for reviews that are handled during the same call as the request and the day of the follow-up phone call for reviews where a decision cannot be made on the day of the request but can still be handled over the telephone. Follow instructions in §12013.8 for information that must be provided to the appellant on the phone and in the determination letter.

12013.4 Time Limit for Requesting a Telephone Review.--A party must request a review by telephone within 6 months of the date of the initial determination as indicated on the EOMB/ MSN. The date of filing for a telephone review is considered the date of the phone call.

Requests for extensions to this period for good cause must be requested in writing and are not applicable for telephone reviews. If a party wishes to have good cause considered over the telephone, advise him/her that he/she must submit the request for review along with a request for good cause consideration in writing. (See §12008 for a discussion on good cause.) Count the request as a dismissal.

12013.5 Review Requests Made on Behalf of the Party on the Telephone.--In cases where the beneficiary wishes to have a representative, follow instructions in §12004 on Appointment of Representative. A completed Form CMS-1694-U4 (or other substitution described in §12004.3, Subsection C.) must either be faxed during the phone call or before the phone call is placed and later mailed for the case file.

If the form cannot be faxed, advise the caller that the review cannot be conducted over the phone. In this situation you must transfer the request to the written review unit. The caller does not need to submit a new request for review. Follow the instructions in §12004.8(A)(1) and instruct the caller that he/she will have 14 days to submit the appointment in order to represent the beneficiary.

12013.6 Conducting the Telephone Review.--

Prior to conducting a telephone review, the caller must provide the following three items:

- Beneficiary name;
- Beneficiary date of birth; and
- Medicare health insurance claim (HIC) number.

The following items must be obtained/recorded/confirmed during telephone review:

- Date of call;
- Name of caller;
- Phone number of appellant;
- Name of provider/supplier of item or service;
- Date of initial determination;
- Dates of service for which the initial determination was issued;
- Which items(s) or service(s) are at issue in the appeal;
- Reason for the review request;
- Any new information that is received during the telephone call;
- Rationale for decision or dismissal;
- Name of Reviewer; and
- Confirmation number, if applicable.

12013.7 Documenting the Call.--The information you receive during the telephone review (especially the date of the call) must be either: (1) documented on a review documentation form; or (2) logged into your computer system.

All documentation must be assigned a review control number. Any additional documentation you receive must be recorded into your system or attached to the review form. Record the telephone review control number on all documents you receive that are associated with the telephone review. Include the documents in the file.

Make certain the documentation is made a part of the file and is available if a further appeal is filed or other post-adjudication action is necessary. If the request is later transferred to the written review unit, this documentation must be included in the file in place of the written request for review. All documentation should be maintained in a manner that allows for future audits.

12013.8 Timely Processing Requirements.--See §12012.4 for timely processing requirements.

12013.9 Review Determination Letters.--Inform the appellant of your decision at the conclusion of the call if you have completed the review. Also advise him/her of his/her rights to the next level of appeal if the decision is not fully favorable. Inform him/her that he/she will receive a written confirmation of the decision in the form of either a review determination letter or an adjusted EOMB/ MSN, whichever is appropriate. Send a review determination letter using the instructions located in §§12012.6 and 12012.5 to the appellant with copies to each party and authorized representative when the initial determination is not fully favorable. If the determination is a full reversal (i.e., is fully favorable), send all parties and appointed representatives an adjusted EOMB/MSN or RA. You should not issue a review determination letter. The EOMB/MSN provides the beneficiary with information as to their financial liability with regard to the claim(s) that are now payable. Include in the determination and/or EOMB/ MSN a statement advising the appellant that the telephone conversation constituted a Part B review and decision. The written determination must contain a statement advising the appellant of their rights with respect to further administrative appeal. (See §§12012.5 and 12012.6 for more information about review determinations.)

12013.10 Education.--Develop a process to decrease the occurrence of reviews involving repeated issues by educating provider personnel as well as providing feedback on clerical errors to your claims examiners. Where possible and applicable, use the telephone review as an opportunity to educate appellants and correct systemic problems. (See §12040.2 for more information.)

12013.11 Monitoring Telephone Reviews.--Develop a process to monitor telephone reviews. At a minimum, monitor 45 telephone reviews or 5 percent of telephone reviews per quarter, whichever is less. Monitor the sample of telephone reviews for accuracy, customer service, and adherence to the Privacy Act as well as to ensure that appellants are informed of their rights to the next level of appeal if the decision is not fully favorable. If you randomly monitor calls, make sure the reviewer informs the appellant that the telephone call may be monitored.

Also develop a process to perform ongoing quality checks to ensure accuracy of information, to ensure payment is correct and to ensure information regarding further appeal rights are provided at the end of the call for all upheld and partially reversed decisions.

Document and retain any reports you generate through your quality control process. Retain this information in accordance with your normal document retention procedures.

12014. HEARING OFFICER (HO) HEARING - THE SECOND LEVEL OF APPEAL

A party dissatisfied with your review determination, where at least $100 remains in controversy, may request a Hearing Officer (HO) hearing. The HO hearing is the second level of appeal, performed after a review determination has been issued by you. It is a new and independent review of the claim by a hearing officer. If a review determination has not been issued, there is no right to a HO hearing, except in the two specific cases (claims for payment not acted upon with reasonable promptness by you, and appeals of revised initial determinations where $100 or more remains in controversy), discussed below.

You must establish and maintain hearing procedures for individuals dissatisfied with your review determinations. The hearing process gives a dissatisfied party an opportunity to present the reasons for his/her dissatisfaction and to receive a new decision based on all the evidence developed at the hearing. A party to a review determination is entitled to a hearing if a written request is filed timely and if the amount remaining in controversy at the time the request is filed is $100 or more.

12014.1 Filing a Request for HO Hearing.--The request for HO hearing can be filed with you, CMS, or an office of the SSA, or with the RRB for RRB beneficiaries. The request must be made in writing and signed by the party making the request. A representative may also file the request. The request may state that the appellant is dissatisfied with the review determination and wishes to appeal the matter further, or it may merely be a second request for appeal, and your records indicate that a review has previously been conducted. A request may be any clear expression, in writing, by a party (or their representative) that states, in effect, that he/she is dissatisfied with your review determination and contains the necessary information to complete the appeal.

A. Request for Hearing - Part B Medicare Claim (Form CMS-1965).--CMS provides a form for filing a request for hearing for the convenience of appellants, but use of the form is optional. Provide these forms upon request by an appellant. When a request for hearing is filed using Form CMS-1965, date stamp the form with the date that the request is received in the corporate mailroom and attach the envelope or an image of the envelope that the request was mailed in to the request. (See Exhibit 3 for a copy of Form CMS-1965.)

B. Other Written Requests.--As use of Form CMS-1965 is optional, any written and signed statement of dissatisfaction and desire to appeal the matter further that contains the same information that the form would supply is sufficient. Follow instructions in §12012.2(B)(3) for requests made by beneficiaries. Upon receipt, date stamp the request with the date that it is received in the corporate mailroom, and attach the envelope or an image of the envelope to the request.

NOTE: In situations where you think timeliness may become an issue, you must maintain the envelope in the case file. If the appeal request is submitted in a box, image or copy the post mark date and any other identifying information.

C. Request Submitted to the Wrong Carrier.--Sometimes an appellant may incorrectly submit a request for HO hearing to you. If the initial determination and review determination were correctly processed by another carrier, do not automatically consider it a request for transfer. Forward the request to the carrier with jurisdiction over the claim, and therefore over the HO hearing request, as soon as possible.

12014.2 Time Limit for Filing A Request for HO Hearing.--A party must file a request for HO hearing within 6 months of the date of the notice of the review determination, or revised initial or review determination. The date of filing is defined as the date the party mailed the request for HO hearing, as evidenced by the postmark on the envelope. Therefore, the envelope or an image of the envelope must be attached to the request in the corporate mailroom. In situations where you think timeliness may become an issue the envelope must be attached to the request. The envelope itself or the image of the envelope becomes part of the development of the appeals case file. If the party has filed the request in person with either you, CMS, or an office of the SSA, or with an office of the RRB for RRB beneficiaries, then it 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 hearing to a CMS, SSA, or RRB office, the date of filing is the postmarked date on that envelope.

Where claims are combined to meet the $100 amount in controversy requirement, all review determinations must have been issued within 6 months of the filing of the hearing request.

You may, upon request by the party, extend the period for filing the request for hearing. If you find good cause for late filing of the hearing request exists then the request should be handled as if it had been timely filed. (See §12008 - Extension of Time Limit for Filing a Request for Review or HO Hearing.)

If the appeal request was not timely filed, but it appears from the case file that the claim(s) should have been paid in whole or in part, although the HO must dismiss the request for HO hearing, the HO may forward the case file to you with a note explaining why he/she believes the claim(s) may be payable and asking the carrier to determine whether there is authority to reopen the review determination under the reopening authority.

12014.3 Request for HO Hearing Filed Prior to a Review Determination.--A review determination is a prerequisite for a HO hearing, except in the two specific exceptions discussed in §12014.4, below. Handle a request for HO hearing filed prior to a review determination as a request for review.

12014.4 Exceptions to Filing Requirements.--Although in most cases a request for HO hearing filed prior to a review determination will result in the appeal being handled as a request for review, there are two specific exceptions to this requirement.

A. Claim for Payment Not Acted Upon with Reasonable Promptness.--If you do not process a claim within 60 consecutive days from the day you received it, a party has the right to a HO hearing if there is any clear expression in writing submitted by the party asking for a hearing to adjudicate the claim. (See 42 CFR 405.801 and 405.802)

Determine whether the request for payment was filed more than 60 days earlier and determine whether you have taken any action before the hearing request was received. If you have not taken any action, the HO assigned the request will direct you to notify the beneficiary of the reason for the delay and to begin processing the claim within 10 working days. If you comply with the HO's request and also provide the HO with a copy of your notice to the beneficiary, then the HO dismisses the hearing because action is being taken on the initial payment request.

If you do not comply with the HO's request, then the HO prepares for a hearing, and provides you with a copy of all notices sent to the beneficiary. If appropriate, the HO may perform a preliminary On The Record hearing.

B. Reopened Determinations (revised initial determinations).--Following your issuance of a revised initial or review determination (pursuant to your reopening authority), all parties to the revised determination have a right to a hearing if they meet the requirements for filing a request for HO hearing (i.e., they meet the time limits for filing and the amount remaining in controversy is $100 or more).

Where the revised initial determination was issued as a result of actions initiated by you, and less than $100 remains in controversy after you issue a revised initial determination, all parties have a right to request a review.

12016. REQUEST FOR HO HEARING

12016.1 Timely Processing Requirements.--Ninety percent of final determinations must be issued within 120 days of the date of receipt of the request for HO hearing. The date of receipt for purposes of this standard is from the date of receipt of the request for HO hearing in the corporate mailroom.

NOTE: At your discretion, you may consider and honor requests for immediate hearings for reasons such as threat of bankruptcy or other emergency situations.

12016.2 Carrier Responsibilities - General.--You must forward the hearing request and all relevant material to either the area that handles HO hearings, or to the assigned Hearing Officer, as soon as possible but no later than 30 calendar days after your receipt of the request in the corporate mail room. Relevant material includes, but is not limited to, all information used to make the initial and review determinations and copies of, or references to, any relevant statutes/regulations/coverage determinations used in making the review determination, including all pertinent LMRP or RMRP and relevant manual provisions in effect at the time the initial determination was made. The suggested contents of the appeals case file are discussed in detail later in this section.

If, while assembling the file for forwarding to the HO, you notice that a denied claim is payable in full (i.e., Medicare allowable amount) you must notify the HO that the claim is payable and why. If the HO agrees, the HO may then conduct a preliminary on-the-record hearing and issue the full reversal.

12016.3 Requests for Transfer of In-Person Hearings.--Transfer is primarily intended to accommodate beneficiary appeal requests for in-person hearing. (See 42 CFR §405.825(a) - Location of carrier hearing.)

A. Beneficiary Requests.--Transfer may be used to accommodate either (1) beneficiaries who live in one part of the country part of the year, but spend an extended period of time in another part of the country for part of the year; or, (2) beneficiaries who are being represented by a son/daughter/relative where the representative lives in one part of the country, and the beneficiary lives in another. There may be other similar situations that would warrant approval of a beneficiary's transfer request. The overriding consideration is to provide access for a beneficiary to an in-person hearing.

Following receipt of a transfer request from a beneficiary, you may advise the beneficiary that a telephone hearing is available, although you may not require that the beneficiary accept a telephone hearing in place of an in-person hearing.

B. Physician or Other Supplier Requests.--Transfer has very limited application for physicians or other suppliers. Physicians or other suppliers with appeal rights are expected to pursue their appeals through the carrier that processes their claims. For transfer requests from physicians or other suppliers, there must be extenuating circumstances present for granting a request for transfer.

NOTE: Extenuating circumstances does not include the desire by a physician or other supplier to have a particular representative from another state or area of the country represent them. There is a strong presumption that there are competent/suitable representatives available to a physician or other supplier in the contractor's service area.

C. Applicable Medical Review and other Coverage and Payment Policies.--The coverage, medical review, and other payment policies in place at the contractor that processed the initial claim for payment are binding upon the HO at the receiving contractor that will be conducting the in-person HO hearing. The transferring contractor is responsible for fully developing the case file prior to forwarding to the receiving contractor, and providing all relevant documents needed to adequately review and rule on the claim for payment.

D. Procedure for Processing and Handling Approved Transfer Requests.--When a transfer request is granted, the primary carrier is responsible for developing the case file. Forward the request and case file within 21 calendar days of the transfer request. If the primary contractor conducts a POTR, the primary contractor counts the hearing as part of their workload up until it is transferred to the secondary contractor. If the secondary contractor performs the hearing, it is counted as part of their workload. The primary contractor must not "recount" the request when it is transferred back to them.

1. Preliminary OTR Hearing Decisions.--You may, at your discretion, conduct a preliminary on-the-record (OTR) hearing. If you conduct a preliminary OTR hearing, and the decision is favorable, send a copy of the OTR hearing decision to the appellant. Follow the procedures for issuing preliminary OTR hearing decisions in §12017.4. If after following the procedures for issuing preliminary OTR hearing decisions the appellant advises that he/she still wants an in-person hearing, then forward the case file to the carrier closest to the appellant (e.g., closest to where the beneficiary is temporarily residing or where the relative/representative resides) within 7 calendar days of your receipt of the notice from the appellant that an in-person hearing is still desired.

If the preliminary OTR hearing decision is unfavorable, transfer the case file, including the preliminary OTR hearing decision, to the carrier closest to where the appellant is located (e.g., closest to where the beneficiary is temporarily residing or where the relative/representative resides). Send the case file to the secondary carrier within 14 calendar days of the appellant advising you that he/she does not accept the favorable preliminary OTR hearing decision. The secondary carrier must complete the in-person hearing within the 120 day timely processing standard (which started running when the primary carrier received the request for HO hearing). The secondary carrier returns the case file and HO hearing decision to the primary carrier for effectuation.

E. Special Rules for Durable Medical Equipment Regional Carriers (DMERCs).--DMERCs are to follow the instructions on transfers contained in the statement of work for DMERCs.

12016.4 Acknowledgment of Request for HO Hearing.--Within 21 calendar days of receipt of the request in the corporate mailroom, you or the HO assigned the request must send a letter to the appellant acknowledging receipt of the hearing request.

A. Acknowledgment Letter.--Use the following language and format for acknowledging receipt of the request for HO hearing. The language will need to be modified, depending upon whether it is you or the HO assigned to the case that is sending out the acknowledgment.

MODEL ACKNOWLEDGMENT LETTER FORMAT AND STANDARD PARAGRAPHS.--

CMS alpha representation

MEDICARE
PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

ACKNOWLEDGMENT OF REQUEST FOR PART B HEARING OFFICER HEARING

Date:

Appellant's Name
Appellant's Address
Appellant's Party Status (either beneficiary, physician, or supplier)

RE:
Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Physician/Supplier Name:
Date(s) of Service:
Type(s) of Service:

Dear Name of Appellant:

Your request for a Hearing Officer hearing was received on [date that hearing request was received in the corporate mailroom].

[If inserting paragraphs A1, A2, or A3, use one of the following sentences:]
A Hearing Officer will be assigned to this case who will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit. [OR] I am the Hearing Officer assigned to this case, and I will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit.

[NOTE: Insert the appropriate "A" paragraph, found at the end of this section, here:

If an on-the-record was requested, insert A1.

If no specific type of hearing was requested, insert A2.

If appellant requests an in-person or telephone hearing, insert A3.].

[NOTE: Insert the following two paragraphs if the appellant is a beneficiary:]

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify.

In addition, volunteers at Medicare peer counseling programs in your area, such as [name of local state counseling programs, such as State Health Insurance Assistance Programs (SHIPs), Local Department on Aging, etc.] can also help you. If you would like more information on how to get in touch with a counselor, please call the number provided at the top of this letter.

[Complete the letter by providing your name and a phone number, as follows]:

If you need more information or have any questions, please do not hesitate to call the number provided at the top of this letter or to write to the address provided at the bottom of this letter.

Sincerely,

Medicare Hearing Officer [OR]
Carrier staff member name

cc:
Beneficiary(s) [when beneficiary is not the appellant]
[Protect privacy if case involves multiple beneficiaries]
Physician/supplier
[if physician/supplier has appeal rights or is acting as representative of the beneficiary]
Representative [when applicable]

Medicare Government Services
12345 Dogwood Way, P.O. Box 567
Anytown, USA 09876-5432
A CMS CONTRACTED CARRIER

Standard "A" Paragraphs for Acknowledgment Letter

A1: On-the-record decision requested:

You asked for a decision based on the record rather than an in-person or telephone hearing. Therefore, your file will be examined and a decision made based on the information we have. If you have additional information about your case that you want considered, please forward it to the above address as soon as possible. In most cases, a decision will be issued within 120 days of your request.

A2: No specific type of hearing requested:

In your request you did not specify if you would prefer an in-person hearing, a telephone hearing, or a decision based on the information already in the file (called an On-the-Record Hearing). [At your discretion, you may send a self addressed, pre-paid post card that contains a checklist of hearing options with short explanations from which the appellant can choose. Or, you can call or otherwise contact the appellant to determine the type of hearing requested. If the appellant is a physician or other supplier, you may advise the physician or other supplier to contact you to state which type of hearing is requested.]

A3: In-Person or Telephone Hearing Requested:

A notice will be sent to you about your [indicate in-person OR telephone] hearing. The notice will contain information concerning the conduct of the hearing, the submission of evidence, and the issues to be decided. In most cases, your hearing will be held and a decision will be issued within 120 days of your request. If you have not received notice about scheduling your hearing within 90 days of submitting your request, contact us at the number above.

12016.5 Case File Development.--The foundation for an effective, efficient and accurate appeals system is the case file. It is essential that the case file contain all relevant information and evidence concerning an appeal so that a correct and fair determination can be made by the HO. Incomplete, missing or unintelligible evidence will inevitably lead to poor decisions and the incorrect payment or denial of Medicare claims. In addition, poorly developed case files can cause poor or incorrect appeal decisions at subsequent levels of appeal. Therefore, you are to ensure that all relevant evidence is included in the case file. This includes all evidence concerning the initial determination, including but not limited to: medical review, fraud units, coverage and payment policy, and other areas. If you maintain procedures and policies online, you may wish to note in the file where a specific policy and/or procedure resides in the system, this will make for easy download during the appeals process.

At the HO level, you must make every effort to ensure that all relevant information is included in the case file, and if the evidence is absent, to attempt to obtain the missing information. To facilitate this responsibility, when assembling the case file for the HO hearing, complete, sign, and attach to every hearing case file a Case File Summary Sheet. This sheet must have all of the information contained in the Model Case File Summary Sheet found below.

In addition to the above, you must make every effort to coordinate with the areas responsible for medical review (including pre- and post-payment review activities), and fraud and abuse units, in order to determine if there exists additional evidence for the case file as to why the claim was denied, and to provide such areas the opportunity to submit the most recent evidence, documentation, etc., into the appeals case file.

Evidence originating from the fraud unit should be included in the case file if it will not jeopardize a fraud investigation. If information from the fraud file is included in the file, then the appellant has a right to review that information. Such evidence, however, may not be used by the adjudicator to make an actual fraud determination, as the HO does not have legal authority to make a finding of fraud. However, this evidence may be used to determine whether the services in question were rendered, or were rendered as billed, or to assess the credibility of any party or representative. Such evidence may also be used to make coverage or payment determinations.

12016.6 Case File Preparation.--The amount and variety of information that should be included in the case file can be quite extensive. In order to secure all relevant information, there must be coordination among all areas that deal with claims processing and the review and denial of claims. In order to promote standardization across all contractors, all evidence/documentation should be put into the case file in a set order prior to the HO hearing.

A. Coordination with Other Areas.--Work with other areas to develop a mechanism to provide notification of requests for HO hearing. Interested areas include, but are not limited to, the medical review and fraud units, MSP, overpayments, etc. The purpose of this mechanism is to secure all evidence or other documentation relevant to the appeal for inclusion in the case file. It is within your discretion how you develop and implement this mechanism. For example, you may determine that the appeals unit will notify the medical review unit only when the appeal involves an overpayment determination that exceeds a certain dollar threshold. Or, for example, you may have the appeals unit develop a log-in of all requests for HO hearing, that other units within the carrier can access and track.

B. Recommended Case File Order.--Build the case file from the bottom up, with the oldest set of documents on the bottom, and the most recent set of documents on top. However, do not place the medical documentation on the bottom. Although this documentation should generally be the oldest (as it presumably existed before the claim was submitted), place it in a separate and distinct section about mid-way from the bottom. The bottom set of documents of the case file would generally contain all of the documentation from the initial claim determination.

The following is a list of the documents generally included in any case file. Note that there may be others not listed here. For applicable items, include originals and retain copies for your records. If you are unable to include the original documents, include copies that are true facsimiles of the original documents. Arrange the following documents, in descending date order (i.e., claim form is on the bottom):

Procedural Documents

- Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- EOMB/MSN/RA (facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- Review request;
- Review determination;
- HO Hearing request [including envelope or image of the envelope];
- Acknowledgment of Request for HO Hearing; and
- Appointment of representative form (Form CMS-1696-U4 or SSA-1696-U4) or other written authorization, if applicable.

Medical Documents

- Medical records, separated by facility or doctor, in chronological order (most recent on top);
- Referral to/from your medical staff, with professional qualifications of the reviewer noted in the document, if applicable;
- Carrier medical policies and opinions relevant to claim(s). (In addition to carrier medical policy, you should include in the case file any information you have as background to the particular policy at issue. For example, findings of the CAC with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies who may have commented on the policy during the development phase, etc.) (See MCM, §7501.2.C for additional information.);
- Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, regional medical review policies, newsletters, any other information used by the Hearing Officer;
- Any other exhibits that you may consider important for the HO to consider (e.g., certification of reasonable charge, fee schedule information, notices of non-coverage, carrier publications, etc.); and
- Any additional evidence submitted by the appellant.

NOTE: This is the suggested case file order, you are not required to use this order. However, you should make every effort to ensure that the appropriate documentation is in the case file. Using this case file order and arrangement will assist the HO in making correct and fair determinations and will expedite the process of preparing cases if appealed to the ALJ.

C. Recommended Method for Assembling the HO Hearing File:

- Use a standard 9" X 12" folder or accordion folder. If a tape of the hearing transcript is included, place it in an envelope and staple the envelope securely to the left hand side of the folder;

- For aggregate requests filed by a beneficiary, keep the documents relating to treatment from each physician or supplier together. Separate the documents relating to each physician or supplier by a blank sheet of paper;

- For aggregate requests filed by a physician or other supplier, keep the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. Separate the documents relating to each beneficiary by a blank sheet of paper. Provide a complete set of procedural documents for each beneficiary; and

- Group procedural documents together in chronological order and group medical documents together in chronological order.

D. Case File Summary Sheet.--The Case File Summary Sheet documents the evidence included in the case file. It provides consistency and order to all the documents that are used to make the HO hearing decision. It allows anyone picking up the case file to quickly determine what documents are contained in the case file. The case file summary sheet itself is placed on top of the documents.

Following the HO hearing, there may be documents that the HO will add to the case file. The HO adds documents to the top of the case file, assigns an exhibit number, and amends the case file summary sheet to reflect the added documents. Mark exhibits so that the last received has the highest number or letter. The HO may reference documents contained in the Case File Summary Sheet exhibits list in his/her decision.

E. Model Case File Summary Sheet.--The following summary sheet should be printed on your letterhead, thereby providing easy identification of the contractor preparing it.

Model Case File Summary Sheet

1. Contractor Name:_____
2. Control No(s):_____
3. HIC No.:____-___-____
4. Bene. Name (last, first):_____
5. Physician/Supplier No.:_____
6. Physician/Supplier Name:_____
7. Date(s) of Svs. (mm/dd/yy): ___/___/___ ___/___/___ ___/___/___
8. Appellant (check): Physician/Supplier: ___ Bene.: ___

8a. Rep's. Name: _____ Rep for:_____

9. Claim(s): Assigned: ___ Unassigned: ___
10. Hearing Requested:____On the Record
    _____Not indicated ____Telephone
    ____In Person
11. **Exhibits List**:

    a) Claim form or printout, if electronically generated;
    b) EOMB/MSN/RA;
    c) Review request;
    d) Review determination letter or EOMB/MSN/RA;
    e) HO Hearing request;
    f) Acknowledgment of Request for HO Hearing;
    g) Appointment of representative form (Form CMS-1696-U4 or SSA-1696-U4) or other written authorization;
    h) Medical records, separated by facility or doctor, in chronological order (most recent on top);
    i) Referral to/from your medical staff, with professional qualifications of the reviewer noted in the document;
    j) Carrier medical policies and opinions relevant to claim(s). (In addition to carrier medical policy, you should include in the case file any information you have as background to the particular policy at issue (for example, findings of the CAC with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies who may have commented on the policy during the development phase, etc.). (See MCM, §7501.2.C for additional information.)
    k) Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, regional medical review policies, newsletters, any other information used by the Hearing Officer;
    l) Any other exhibits that you may consider important for the HO to consider (e.g., certification of reasonable charge, fee schedule information, notices of non-coverage, carrier publications, etc.);
    m) Additional evidence submitted by the appellant; and
    n) Other (describe or list)

    _____

12. Coordination with Other Areas:
    MR Unit? Yes____ or No_____
    Fraud Unit? Yes____ or No_____
    Other_____? Yes____ or No_____
13. Form Completed By: _____ Phone No:_____
14. Date Completed:_____

NOTICE: THIS FORM AND ALL ATTACHMENTS ARE INCLUDED IN THE APPEALS CASE FILE AND ARE AVAILABLE FOR INSPECTION BY ALL PARTIES, BOTH BEFORE, DURING, AND AFTER THE HO HEARING IS HELD.

Additions to Exhibits List (by HO):

Date Added:_____ Signature:_____

Instructions for Completion of HO Hearing Case File Cover Sheet

1. Self-explanatory
2. Control No.: Enter control numbers (optional)
3. - 10. Self explanatory

For multiple beneficiaries, see below.

11. Exhibits List:

Attach all applicable documents, either directly or by reference. Attachments should be collated and tabbed in the same order as they are shown on this form, with the oldest document or set of documents on the bottom, and the most recent document or set of documents on top.

12. Coordination with other areas:

Signifies notification of the medical review unit and program integrity unit(s) of requests for HO hearing. It is the medical review and program integrity units' responsibility to submit all relevant evidence not already contained in the case file.

13. Self-explanatory

NOTE: This form is intended to develop a full and complete appeals case file. Attach a separate sheet if additional space is needed.

Multiple Beneficiary Information

For cases involving multiple beneficiaries, attach a separate sheet and include the following information:

Beneficiary HIC No.
Beneficiary Name
Date(s) of Svs.
Control No. (Optional)

THIS FORM AND ALL ATTACHMENTS ARE AVAILABLE FOR INSPECTION BY THE APPELLANT. DO NOT INCLUDE ANY PROTECTED/PROPRIETARY MATERIAL IN THE HEARING PACKAGE.

12017. TYPES OF HEARING OFFICER (HO) HEARINGS

There are three kinds of hearings that an appellant may request: In-person, Telephone, and On-the-Record. The nature of the hearings differ with respect to the requirements they impose on you, the hearing officer and the appellant(s), the method of presenting testimony, and the speed with which they can be conducted and a decision rendered.

In terms of development, use of consultants, and consideration and evaluation of the facts, the hearings are similar. The purpose of the hearing is to arrive at the correct decision about the issues in dispute. The appellant must be given the opportunity to decide the type of hearing that is best for him/her. For administrative convenience in processing requests for HO hearing, a preliminary OTR hearing and decision may, at times, be conducted by hearing officers, as appropriate. (See §12017.4, below.)

12017.1 In-Person Hearing.--The appellant and/or his/her representative is afforded the opportunity to present both oral testimony and written evidence supporting the claim, and to refute or challenge the information used to deny the claim or prior payment determination. An in-person hearing may not always be desired or requested by an appellant because it can be time-consuming, inconvenient, or unnecessary.

When an appellant does not request in-person hearing, the HO may hold an in-person hearing if he/she believes that the personal appearance and testimony of the party or parties, and/or of other witnesses, would assist him/her to ascertain the facts at issue in the case. The HO gives notice of the date, time and place to all parties, and conducts the in-person hearing. Failure of a party or the parties to appear at such in-person hearing is not cause for a finding of abandonment. (See §12019.1.A.2, below.)

12017.2 Telephone Hearing.--Telephone hearings offer a convenient and less costly alternative to some appellants and/or their representatives. They differ from in-person hearings by eliminating the need for the appellant or his/her representative to appear in-person. Oral testimony is presented and the opportunity exists for oral challenge. The appellant and/or his/her representative may also submit additional written evidence by mail or fax. Like in-person hearings, telephone hearings are not for everyone, particularly those who may have difficulty presenting their cases. Some, for various reasons, may elect not to present oral testimony. In this situation, an OTR hearing is an available alternative.

Whereas telephone hearings are designed to lower costs and eliminate delays in conducting hearings, the HO may not require that a telephone hearing be held if an in-person hearing has been requested. However, the HO may offer a telephone hearing if:

- Telephone equipment (e.g., tape recorder, speaker phone, conference capability) permits a complete record of the hearing; and,

- Hazardous weather, or repeated rescheduling by the participants, or the appellant's physical health, or long distance travel, make an in-person hearing expensive and inconvenient to the party.

When an appellant does not request a telephone hearing, and has not requested an in-person hearing, the HO may hold a telephone hearing if he/she believes that the live, interactive testimony of the party or parties, and/or of other witnesses, would assist him/her to ascertain the facts at issue in the case. The HO gives notice of the date, time and call number to all parties, and conducts the telephone hearing. Failure of a party or the parties to participate in such a telephone hearing is not cause for a finding of abandonment. (See §12019.1.A.2, below.)

There are times when the above criteria are met but a telephone hearing is not appropriate. These include:

- The beneficiary has requested an in-person or on-the record hearing;
- Overpayment hearing request;
- Hearing request by assignees if the claims of more than three beneficiaries are involved, and the beneficiaries may be liable; or
- Witnesses are involved and the telephone equipment available does not permit more than a two-way conversation or a witness is reluctant to participate in a telephone hearing.

If the above conditions are met, the HO includes an explanation of the telephone hearing option in the "notice of time and place of hearing," and asks that the claimant reply concerning his/her preference for an in-person or telephone hearing.

If the claimant has evidence to present, the HO arranges to receive the evidence before the hearing and acknowledges its receipt. If evidence is introduced during the hearing, the HO asks the claimant to explain, for the record, the portions he/she considers important. The evidence should be identified so that it can be properly associated with the hearing record. The documents should be submitted as soon as possible. The record is kept open until their receipt. If evidence submitted after a hearing reveals unresolved issues or raises new ones, another hearing may be requested.

The HO sends instructions for the telephone hearing to the claimant before the hearing, outlining the procedure to be used and the number to call to start the hearing. If necessary, the HO provides additional information at the time of the hearing.

12017.3 On-the-Record (OTR) Hearing and Decision.--On-the-record hearings and decisions are identical to those rendered in the hearings described above, and follow the same instructions. The major advantage is the speed with which an OTR hearing can be held and decision rendered. The decision is based on the facts that are in the file, including any additional information obtained by, or furnished to, the hearing officer. If the appellant requests an OTR hearing, then the hearing officer will render an OTR hearing decision unless he/she decides that an in-person or telephone hearing would help her/him reach a better, fairer decision. If so, the HO will notify all parties of the time and date of either an in-person or telephone hearing, and explain why an in-person or telephone hearing will yield a better HO hearing decision. If the appellants refuse to appear or participate, then the HO renders an OTR hearing decision based on all the evidence he/she has gathered, including any expert or other testimony that has been gathered.

NOTE: Where an appellant specifically requests an OTR hearing, the resulting OTR hearing decision is not a preliminary OTR decision and the appellant does not have the further option of then requesting an in-person or telephone hearing.

12017.4 Preliminary OTR Hearing and Decision.--Where either an in-person or telephone hearing has been requested, the HO may first prepare a decision based on the information in the file, including any information the appellant wishes to submit. This is called a preliminary OTR hearing decision. Whereas preliminary OTR hearings are useful in situations where the HO is able to issue a decision favorable to the appellant, that is not their only use. They may also be useful in situations where particular appellants routinely appeal the HO's decision to the ALJ level. They should be viewed as a tool to help you and the HO manage the HO hearings case load.

The HO may conduct a preliminary OTR hearing and issue a decision unless one of the following exceptions applies:

- Conducting the preliminary OTR hearing will significantly delay holding the in-person or telephone hearing;

- The HO believes that the facts of the case can be developed only through oral testimony (for example, in certain medical necessity cases);

- A different HO would not be available to conduct the in-person or telephone hearing should the appellant not be satisfied with the preliminary OTR hearing decision; or,

- Workload considerations do not support conducting preliminary OTR hearings. Such considerations would include information that the majority of OTR hearing decisions are not being accepted and appellants are requesting that an in-person or telephone hearing be conducted.

A. Preliminary OTR Hearing.--Preliminary OTR hearings are designed as an administrative convenience in order to shorten the HO hearing process and to help you and hearing officers manage their case load. Appellants do not have the right to request a preliminary OTR hearing, nor is the decision of the HO not to issue a preliminary OTR hearing decision subject to appeal. Hearing officers should evaluate the usefulness of issuing preliminary OTR hearing decisions on a case-by-case basis, but may not make a decision never to conduct preliminary OTR hearings (subject to the exceptions noted above).

B. Issuing Preliminary OTR Hearing Decision.--When issuing a preliminary OTR hearing decision, HOs use the same procedures for issuing a HO hearing decision, subject to the following requirements. The HO includes as the first paragraph in the preliminary OTR hearing decision a statement that although the appellant requested an in-person or telephone hearing, the hearing officer has rendered his/her decision based on the evidence in the file. The hearing officer includes a postage paid, pre-addressed postcard for the appellant or his/her representative to return (the postcard is included in the decision sent to the appellant if there is no representative, but is sent to the representative when there is a representative), either confirming that the appellant still wants an in-person or telephone hearing, or indicating that the in-person or telephone hearing is no longer desired.

NOTE: Instead of including a postcard, you may advise the appellant or representative to respond to you by other means, including by phone, fax, or electronic mail.

If the amount in controversy after the preliminary OTR hearing decision is $500 or more, the postcard (or other means) shall also ask the appellant or representative to indicate whether he/she plans to proceed directly to the next level of appeal, the Administrative Law Judge hearing. Explain in

the OTR hearing decision that if the postcard is not returned or other means of contact initiated within 14 calendar days of the appellants receipt of the decision (and receipt is presumed to be within 5 days of the date on the OTR hearing decision), the preliminary OTR hearing decision will become final, and the appellant will lose his/her right to an in-person or telephone hearing. However, if the appellant contacts you within 6 months from the date of mailing of the preliminary OTR hearing decision and requests an in-person or telephone hearing, the HO has the authority to hold the in-person or telephone hearing if the appellant can show that good and sufficient cause existed for not responding within 14 calendar days. Refer to §12008, Extension of Time Limit for Filing an Appeal, to determine if good cause has been demonstrated. If the appellant establishes good cause for not responding within 14 days of receiving the preliminary OTR hearing decision, the case is counted as a new case and allowed the full 120 days to conduct.

For workload reporting purposes, do not report the preliminary OTR hearing decision as final until after the 14 calendar days for requesting the in-person or telephone hearing have passed.

12018. HEARING OFFICER (HO) AUTHORITY AND RESPONSIBILITIES

12018.1 Hearing Officer (HO) Authority.--The authority of the HO is limited to the extent that he/she must comply with, and is bound by, all provisions of, and regulations issued under, title XVIII of the Act. The HO may not overrule the provisions of the law or interpret them in a way different than CMS does if he/she disagrees with their intent; nor may the HO use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations.

The HO is also bound by CMS rulings, national coverage determinations, other policy statements, instructions, and guides issued by CMS, and contractor-issued local medical review policies (LMRP) and regional medical review policies (RMRP). The HO must consider the applicability of all LMRP or RMRP to the facts of a given claim, and the HO may not disregard or override an applicable LMRP or RMRP.

The hearing decision is a new and impartial consideration of the claim, and although the prior review determination is not binding upon the HO it should be reviewed as part of a thorough review of the evidence contained in the case record.

12018.2 Qualifications and General Responsibilities.--You may designate as a HO an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology. The HO must be independent. The HO must have a thorough knowledge of the Medicare program and of the statutory authority and regulations upon which it is based, as well as CMS rulings, policy statements, and other instructions issued by CMS.

The individual selected must not have been involved in any way with the initial or review determination at issue. Because the proceedings are non-adversarial, the HO should be particularly responsive to the needs of beneficiaries not represented. The HO must protect each party's rights, even if they are represented by counsel. The HO must safeguard the rights of all parties to the hearing while protecting the Government's interest.

The HO may bring unusual problems he/she encounters to the attention of the RO. He/she must differentiate between requests for policy clarification or updates versus ex parte communications with CMS staff with respect to a specific claim before him/her. Ex parte contact is forbidden. You may not restrict a HO from obtaining clarification from CMS on policy matters, nor from discussing problems with the RO.

The HO exercises control and conducts the hearing with order and dignity, regardless of the hearing type. He/she analyzes and evaluates evidence adduced at the hearing, including testimony, documents or other written evidence in the record. He/she encourages the submittal of facts from individuals without causing unnecessary friction, and is objective and free of any influence which might affect impartial judgement. He/she is patient with all parties and witnesses, being particularly aware that Medicare beneficiaries are either older persons or those with physical and/or mental disabilities.

12018.3 Disqualification of HO.--The HO should disqualify himself/herself from acting in a case in which he/she believes that he/she will have a personal prejudice against, or partiality toward, either the appellant and/or the representative; or with respect to any matter in which he/she has a personal interest; or in which a valid objection is raised by a party. (See 42 CFR §405.824 – Disqualification of carrier hearing officer.) Disqualification is mandatory when a HO was involved in any way in the initial or review determination.

Reluctance to handle a particular case is not justification for disqualification. The HO should not disqualify himself/herself due to past or present participation in cases involving the same or similar issues or the same or similar parties and/or representatives. The HO withdraws only for the above reasons, keeping in mind that the primary objective of the HO hearing is to provide an appellant an impartial hearing.

Appellants have sometimes argued that the HO must be disqualified or dismissed because he/she is your employee or is performing duties on your behalf. This is not good cause for disqualification. The U.S. Supreme Court has upheld the use of carrier employees as fair hearing officers (Schweiker v. McClure, 456 U.S. 188 (1982)). The HO indicates that although he/she is not an officer of the Federal Government, he/she is nevertheless acting on its behalf and must comply with the provisions of the Medicare statute, regulations, and instructions.

If a party to a hearing suggests disqualification of the HO, include the party's request and its basis. The record will show how the HO disposed of the suggestion. If the HO, on his/her own initiative or upon objection of a party, disqualifies himself/herself, he/she informs the parties and advises them that the hearing will be rescheduled with a different HO. The HO must prepare a signed, written statement explaining the reasons for his/her disqualification, which statement must be included in the case file. If the HO does not withdraw, the objecting party may present objections at any time prior to issuance of the decision.

If the HO withdraws prior to scheduling the case for hearing, notice to the parties is not necessary. If a notice of hearing is issued prior to withdrawal, the HO notifies all parties in writing, informing them that the date set for the hearing has been canceled (if cancellation is necessary) and that an amended notice of hearing will be sent by the HO to whom the case is reassigned. If the motion for withdrawal and withdrawal occur at the hearing, the oral statements made as part of the record are sufficient.

If a party's pre-hearing objection is considered and the HO decides to conduct the hearing, the HO notifies the objecting party in writing, explaining the reasons and sends a copy of this notice to the other parties. If the ruling not to withdraw is made at the hearing, the statement is included in the record.

12019. HEARING OFFICER (HO) HEARING PROCEDURES

12019.1 Preparation for the Hearing Officer (HO) Hearing.--For the HO to be fully informed, he/she must examine the claim prior to the hearing and, preferably, before the notice of hearing is mailed. The first step in preparing for the hearing is an examination of the evidence, including material submitted with the hearing request. Once the HO completes his/her examination of the evidence and the issues to be determined, he/she examines the applicable sections of the statutes, regulations, rulings, policy statements, general instructions and other formal guides. Additional information may be submitted during the hearing.

A. Dismissal of Hearing Request.--The HO has authority to dismiss the request for HO hearing under any of the following circumstances:

1. Request of Party.--With the approval of the HO, a request for hearing may be withdrawn or dismissed at any time prior to the mailing of the hearing decision upon the request of the party or parties filing the request for such hearing. A party may request a dismissal by filing a written notice of such request with either you, the HO, or by orally stating such request at the hearing. The dismissal of a request for hearing is binding unless vacated by the HO. (See subsection B., below.)

2. Abandonment of Party.--The HO may dismiss a party's request for a hearing if (a) neither the party nor his/her representative appears at the time and place fixed for an in-person hearing or fails to call in for a scheduled telephone hearing; and (b) within 10 days after the mailing of a notice to the party by the HO to show cause for not appearing/calling, such party does not show good cause for his/her failure to appear/call and for his/her failure to notify the HO prior to the hearing that he/she could not appear/call.

3. Dismissal for Cause.--The HO may, on his/her own motion, dismiss a hearing request, either entirely or as to any stated issue, under either of the following circumstances:

- Where the party requesting a hearing is not a proper party or does not otherwise have a right to a hearing; or

- Where the party who filed the hearing request dies and there is no information before the HO showing that an individual who is not a party may be prejudiced by your initial or review determination.

4. Amount in Controversy.--The HO may on his/her own motion dismiss a hearing request where the amount in controversy is less than $100.

5. Appointment of Representative Absent or Invalid.--The HO may dismiss when an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment and the appointment is not corrected within the time limit discussed above in §12004.8(A)(2) or when the individual fails to include an appointment with the appeal request.

6. Failure to File Timely.--The HO may dismiss when the hearing request is not filed within the time limit required and the HO does not find good cause for failure to file timely.

7. If it is clear, based on the evidence in the review file, that the claim should have been paid, the HO may dismiss the case and order you to adjust the claim to make payment in full.

NOTE: In addition, the HO or the hearing department is responsible for ensuring that the payment has been made in accordance with the HO's order.

B. Vacation of Dismissal.--The HO may, on request of a party and for good and sufficient cause shown, vacate any dismissal of a request for hearing at any time within 6 months from the date of mailing the notice of dismissal to the party requesting the hearing.

C. Dismissal Notice.--The HO issues the written notice of dismissal to all parties to the appeal. The HO must include in the notice the information that at the request of a party and for good and sufficient cause shown, the HO may vacate his/her dismissal of a request for hearing at any time within 6 months from the date of his/her mailing of the notice of dismissal. The dismissal notice is sent to the party requesting the hearing at his/her last known address, as well as to his/her representative. The dismissal notice includes the reason for the dismissal.

12019.2 Scheduling the Date, Time and Place of Hearing.--An appellant who requests either an in-person or telephone hearing must be given adequate notice of the date, time and place of the hearing and the specific issues to be determined. The HO works with the appellant, or their representative, to schedule the date and time and, for in-person hearings, the place, as promptly as possible, subsequent to the HO's review of the evidence. The HO holds the in-person hearing at a location reasonably convenient to the appellant and the HO.

NOTE: All references to the appellant include references to the appellant's representative, when present. That is, if the appellant has appointed a representative, the representative becomes the primary contact for the HO, and it is the responsibility of the representative to keep the appellant properly informed of the proceedings and their responsibilities, if any.

The HO provides notice of the hearing at least 14 calendar days prior to a scheduled date. However, if the date and/or time set by the HO is not convenient for the appellant, the HO may contact the appellant by phone to determine a mutually acceptable time. With the appellant's concurrence, the HO may schedule a hearing with less than 14 days notice. The HO may schedule the hearing by sending written notice of the date and time and, for in-person hearings, the place, or may contact the appellant by telephone, facsimile, or electronic mail in order to schedule the hearing, as long as the contact and agreement are documented in the case file.

If the HO rendered a preliminary on-the-record hearing decision, although an in-person hearing or telephone hearing had been requested, and the appellant indicated an intention to proceed with the requested type of hearing, assign a new HO to conduct it. That HO advises the appellant of the arrangements immediately upon confirming them.

NOTE: Where the appellant is a beneficiary, there may be rare cases where the beneficiary's physical condition may require the HO to schedule the hearing at a hospital or other convenient location, so that there is no infringement of the beneficiary's right to a hearing. In such situations, the HO advises the beneficiary that a telephone hearing is also available, but may not require it.

A. Written Notice of Hearing.--The HO must provide a written notice to the appellant, and their representative, before conducting the in-person or telephone hearing. The notice provides information that the appellant will need to prepare effectively for the hearing. Failure to adequately inform the appellant of the nature and purpose of the hearing, including specific information as to the points at issue, may result in denying him/her an essential element of the hearing. Therefore, the

HO phrases this information to be easily understood by a layman while being technically correct and complete. The HO may transmit this notice to the appellant through the mail, by facsimile, or by electronic mail. The notice must get to the appellant before the hearing takes place and with sufficient time to allow the appellant to thoroughly review the notice and take any necessary actions in preparation for the hearing.

B. Elements of Written Notice of Hearing.--The written notice sent to the appellant before the hearing must contain at least the following elements, as appropriate.

For Telephone Hearings:

- Instructions for the telephone hearing, outlining the procedure to be used and the time and date when the call will take place. As necessary, the HO provides additional information at the time of the telephone hearing.
- Information about whether the HO will initiate the call or whether the participants are to call in, and what phone number will be used (e.g., whether the HO will call the appellant(s), or whether the appellant(s) is to call in)--this information can also be communicated by the HO to all appellants, witnesses, representatives, etc., via a phone call; the HO must document such communications in the case file.
- Notification of an appellant's right to request a copy of the case file prior to the telephone hearing.
- Notification prior to the start of the hearing that the proceedings will be electronically recorded. This should also be part of the opening statement made at the start of the telephone hearing.
- Notification that an interpreter can be used, if necessary, upon request of the appellant.
- Notification that the POTR hearing decision, if applicable, will prevail if the appellant does not appear for the scheduled hearing.

For In-Person Hearings:

- Notification must include the place of the hearing, i.e., city, State, street address, floor, and designated room, as well as a telephone number of someone at the carrier/hearings office in case the appellant or someone else needs to contact the HO before the hearing.
- Notification that an interpreter can be used, if necessary, upon request of the appellant.

For both telephone and in-person hearings, the notice must:

- State the purpose of the hearing and include a statement of the issues.
- Include a brief statement of the consequences of the proceeding and of the decision that will follow.
- State the right of the appellant to present briefs or affidavits in lieu of testimony.
- Inform the appellant of the effect of abandonment or a failure to appear at a scheduled hearing.
- Inform the appellant of their right to present oral argument.
- Inform the appellant of their right to be represented by counsel or other representative.
- Inform the appellant of their right to bring witnesses.
- Inform the appellant of their right to bring or send all evidence in their possession, including pertinent records, documents or other writings affecting the issues.
- Inform the appellant of their right to inspect the hearing file prior to the scheduled hearing.

- Inform the appellant that their representative has all the same rights and responsibilities as the appellant.
- Inform the appellant of their responsibility to promptly notify the HO in writing of any circumstances preventing the appellant from participating in the hearing as scheduled.
- Notification that an interpreter can be used, if necessary, upon request of the appellant.
- Notification that the POTR hearing decision, if applicable, will prevail if the appellant does not appear for the scheduled hearing.

NOTE: If an appellant indicates that their representative will pursue the appeal, and the file does not already contain sufficient documentation of representation, the HO must either send Form CMS-1696-U4, Appointment of Representative form (see Exhibit 1), or advise the appellant of the information that must be included on a written appointment of representative.

Place a copy of the written notice of hearing in the hearing case file.

12019.3 Adjournment and/or Postponement of Telephone or In-Person Hearing.--As provided for in regulation, the HO may, for good and sufficient reason, schedule a new time and/or place for the hearing or adjourn on his/her own motion upon reasonable notification to the parties. Good and sufficient reasons include, but are not limited to: sickness of a party, interpreter, or witness; difficulty in scheduling a witness; a person at the hearing (e.g., a party, a witness, or a representative) becoming verbally and/or physically violent or abusive; or, a delay in obtaining additional evidence. Include a statement in the record explaining the reasons for adjourning or postponing the hearing.

A. Violent/Abusive Persons.--The HO may immediately adjourn a telephone or in-person hearing if a person (e.g., a party, a witness, or a representative) becomes verbally abusive and/or physically violent during the course of the hearing. Consult with your RO on next steps. The RO may advise you to conclude an in-person hearing via telephone, and to conclude a telephone hearing by conducting an on-the-record hearing based on the evidence in the case file.

When an HO is scheduling a hearing for a party that has exhibited a history of verbal abuse and/or physical violence at prior hearings or in prior dealings with the HO or you, the HO should schedule a hearing that provides for the safety of the HO and your staff. Consult with your RO in these situations.

B. Repeated Requests for Postponement.--An appellant might repeatedly request postponement. The HO must evaluate the reasons that the appellant requested the postponements. If the HO determines that the appellant does not have a good and sufficient reason for the postponement, he/she does not need to grant the postponement. If the HO cannot justify rescheduling the hearing, and a preliminary OTR hearing was conducted, he/she notifies the appellant (in writing or verbally) that the preliminary OTR hearing decision will prevail if the appellant does not appear for the scheduled hearing.

If a preliminary OTR hearing has not been performed, the HO notifies the appellant (in writing or verbally) that a decision will be made based on the existing record, as well as any supplemental evidence added to the record, if the appellant does not appear for the scheduled hearing. The HO documents such notification to the appellant and the reasons for his/her action in the file. When the HO believes that additional information is necessary, he/she should hold the hearing, and supplement the record as necessary. This could include obtaining oral testimony from, for example, a medical expert, or other witnesses. In this situation, the HO gives the appellant advance notice that the telephone or in-person hearing will take place as scheduled, and advises the appellant that he/she may participate.

12019.4 Pre-Hearing Review of the Evidence.--Once a request for hearing has been filed, the carrier submits to the HO all evidence pertaining to the claim. You must comply with all requests for evidence made by the HO. The HO evaluates the evidence in the file, as well as any other documentary evidence the parties submit, before the hearing is scheduled. When evaluating the documentation submitted, the HO considers the reliability of the source, the factors present that may limit the impartiality or accuracy of the statements, and whether it is compatible or in conflict with other evidence. The HO determines whether there is sufficient documentation to make an impartial decision on the issue.

Other areas within the carrier may have information relevant to the claim(s) at issue. For example, the program integrity area (including medical review, overpayments, and fraud and abuse) may submit evidence to you for inclusion in the case file. If other areas have information, allow them no more than 2 weeks to submit the relevant information to you. Such evidence must be made available for inspection by an appellant upon request. The HO must exercise care in determining the weight to give fraud and abuse information 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 denial of the claim(s).

A. Witnesses.--The HO may invite carrier witnesses to the hearing to clarify and/or explain a policy. Such witnesses could include, for example, the Carrier Medical Director, or a staff member from the medical review or fraud unit. The HO may also invite witnesses outside the carrier. The HO may not discuss a specific claim/appeal with carrier staff or outside persons without including all appellants and representatives in such discussion. If the HO requests written information or opinion from a witness, the HO must provide copies to the appellant and representatives. This is to ensure that all information used or gathered by the HO is available to all appellants.

As necessary, the HO may ask the CMS Regional Administrator to issue a subpoena directing a witness to appear and testify.

B. Beneficiary Protection.--Whereas the appellant is responsible for securing the needed evidence to support his/her claim, the HO works to protect a beneficiary-appellants rights by making every effort to insure that sufficient evidence is obtained, particularly when the decision is based "on-the-record." To the extent possible, assist a beneficiary who is unable to secure necessary information.

C. Conflicting Evidence.--If the HO sees that evidence on some point is conflicting, inconclusive, or wholly lacking, the HO considers how it may best be resolved before scheduling the hearing. The HO considers the need for a consultative physician or other expert. In order to avoid delay that might result from the absence of a key witness or the lack of some essential evidence, the HO must make every effort to ensure that all evidence and witnesses will be available. The HO obtains additional necessary evidence to complete development of the case through appropriate channels from you, the physician or other supplier, or from any other source.

D. Admissibility of Evidence.--Evidence may be considered even though it might be inadmissible under rules of evidence applicable to the courts. The materiality and relevance of the evidence are the controlling criteria with respect to admissibility of evidence at hearings, rather than the particular form in which it appears. The HO resolves doubts about including a particular document as an exhibit by including it, and the HO also determines the weight to be given to the evidence. Determining the issues and selecting the documentary evidence are especially important if the decision is based on-the-record.

12019.5 Forwarding Copy of Case File Prior to Telephone Hearing.--The appellant has the right to request a copy of the case file prior to the telephone hearing. The appellant should be advised of this in the notice of the hearing. (See §12019.2 (B).) Upon receiving such a request, provide an appellant a copy of all documents in the case file, except do not provide copies of documents that are already in the possession of the appellant or his/her representative. Forward documents to the appellant prior to the telephone hearing.

If the appellant has documentary evidence to present, the HO arranges to receive a copy of the evidence before the telephone hearing, and acknowledges its receipt either in writing or via telephone. If documentary evidence is introduced during the hearing, the HO asks the appellant to explain, for the record, the portions he/she considers important. The evidence should be identified so that it can be properly associated with the hearing record. If the appellant has documentary evidence to submit after the hearing, the documents should be submitted as soon as possible but no later than the date set by the HO. The record is kept open until the documents are received, but will be closed if they are not received within the time limit set by the HO at the hearing. If evidence submitted after a hearing (but before a decision is issued) reveals unresolved issues or raises new ones, the initial hearing should be continued with an explanation why to the appellant.

12019.6 In-Person and Telephone HO Hearing Procedures.--The HO notifies the appellant or representative that there are major differences between a Part B hearing and a formal court proceeding. The hearing is non-adversarial in nature in that neither you nor CMS is in opposition to the appellant, but is interested in a proper decision. Therefore, formal objections and other accepted court procedural tactics are not appropriate. Rules of evidence and proof are less restrictive than those used in court. The HO's role is that of an impartial trier of the facts, and he/she considers as evidence any testimony or documentation that enables him/her to make a correct decision.

During hearings, the HO questions participants to develop evidence and establish facts. For example: new evidence may be presented throughout the hearing; witnesses may be asked to testify more than once; appellants do not need to make a final statement; and, an appellant has the right of rebuttal after evidence adverse to his/her case has been presented.

A. Rights of a Party at the In-Person or Telephone Hearing.--The rights that a party may exercise at a hearing stem from the basic right to due process. They include, but are not limited to, the right:

- To present oral arguments and/or written statements as testimony;
- To be represented by an attorney or other qualified individual (e.g., appointed representative (See §12002), etc.);
- To bring witnesses to testify on his/her behalf;
- To bring and present all evidence in his/her possession, including pertinent records, documents, or other information;
- To question witnesses and other parties;
- To examine the evidence prior to and during the hearing, as well as to examine and comment on any evidence added to the record subsequent to the hearing, regardless of who supplies the evidence;
- To register objections to the inclusion of any document in the record; and,
- To respond to evidence adverse to his/her case.

The HO is responsible for making sure the parties are aware of their rights before the hearing begins. Usually this has already been done in the Notice of Time and Place of the Hearing. (See §12019.2, above.) However, if it appears to the HO that a party is not exercising his/her rights, the HO may also review one or more or all of them at any time during the hearing for the benefit of those present.

The HO gives all parties an opportunity to inspect the evidence before the hearing, so they may prepare for the case. However, for an in-person hearing, if the hearing itself is the only time available to review the evidence, the HO gives them an opportunity to inspect the evidence before the testimony begins. The HO or his/her designee must always supervise a party examining evidence to ensure that nothing is removed, defaced, or added. When additional information is furnished after the hearing, parties have the opportunity to read it and offer comments.

B. Opening the Hearing.--The HO opens the proceedings by stating that the hearing will be tape recorded. The HO then introduces himself/herself, and explains that he/she will preside at the hearing. Next, the HO identifies the parties, their representatives and witnesses, and enters their names, official titles and interest into the record by giving their full names and their purpose in attending (e.g., Mr. John Jones is the beneficiary-appellant, and Dr. Ellen Smith is an expert witness). In rare circumstances, a stenographer will be used, in which case the stenographer should also be introduced.

The HO then formally opens the hearing with an opening statement. (See subsection C., below.) One purpose of the opening statement is to allow the HO to briefly summarize the purpose of the hearing and the issues involved. Appellants or representatives who disagree with the summary of the purpose and the issues are then given an opportunity to briefly respond if they disagree. After listening to the reasons for disagreeing, the HO then modifies the summary if necessary.

Once the opening statement has been read and agreed to, the HO begins taking testimony.

C. Opening Statement.--The HO begins the hearing with an "opening statement", which sets the tone for the hearing, focuses attention upon its purpose and the issues involved, and explains how it will be conducted. The HO prepares the statement in writing in advance of the hearing.

Although the HO draws the contents of the opening statement from the facts of the specific case, he/she also includes the following:

- Identification of the hearing by beneficiary's name and health insurance claim (HIC) number(s), issue(s) involved, and the statement that the hearing is now open;

- The regulatory citation that provides for a party’s right to a hearing, which, at time of publication, was: 42 CFR Part 405, Subpart H, §405.822 (CFR stands for Code of Federal Regulations);

- Identification of the HO in a statement of authorization for conduct of the hearing;

- A statement that the hearing will be conducted in an informal manner, and that the formal rules of evidence are not applicable;

- The procedural history concerning pertinent facts and dates, including facts revealed by documents in your file, e.g., entitlement to coverage under the supplemental medical insurance plan, deductible met, services covered, etc.;

- The issues to be resolved, the pertinent sections of the statutes and regulations, and how the two relate;

- Discussion of the penalty provision (see subsection D., below) for providing false or misleading statements;

- The need to speak clearly for the record as the hearing is being recorded; and,

- An explanation of the formal aspects of the hearing, including the following:

  - A formal record of the proceeding will be made;

  - The record will consist of the documentary evidence and the testimony;

  - Only one person will testify at a time;

  - The witnesses may be examined or cross-examined by the parties, their representatives, and the HO himself/herself; and,

  - The parties may submit a statement or brief of proposed findings at the end of the testimony or after the close of the hearing.

Circumstances may require modification of the written opening statement. The HO includes in his/her statement any relevant occurrence or situation that warrants special mention.

After reading the opening statement, the HO asks the participants whether the opening statement is a correct and accurate account. If any misunderstandings are evident in the participant's responses, the HO clarifies them by offering suitable explanation(s). For hearings where no beneficiaries are participating or attending, the HO may decide to waive the reading of the opening statement into the record, but only if the appellant and all those present have been provided with a copy of the opening statement.

D. Oaths, Affirmations, and the Penalty Provision.--The HO has no authority to administer oaths or affirmations. However, at some point during the opening statement, the HO advises the parties and witnesses of the penalties for false statements and/or misrepresentations. Since the following language may frighten/confuse some appellants, the HO does not have to read it verbatim, as long as the parties and witnesses are made aware of the penalties. However, the HO must read §1128B(a) to all physician or other supplier appellants, even when the HO does not read the opening statement.

"Section 1128B(a) of the Social Security Act prohibits the making of false statements or representations of material fact in any application for a benefit or payment under title XVIII; the concealment or failure to disclose any facts concerning benefits; or the conversion of payments made under title XVIII for one person to the benefit of another. A physician or other supplier of items or services who takes such action may be found guilty of a felony and may be fined not more than $25,000 or imprisoned for not more than 5 years, or both. Any other individual who takes such action may be found guilty of a misdemeanor and fined up to $10,000 or imprisoned for not more than 1 year, or both."

E. Principles of Questioning.--Generally, it is the HO who does the bulk of the questioning. This facilitates the proceedings by pinpointing the issues and eliminating those that are irrelevant or immaterial. This also helps hesitant and inarticulate witnesses. Where counsel is present, less questioning may be needed. Careful questioning helps ensure a fair and complete hearing record and decision. This may prevent the need for a second hearing. Generally, the requesting party begins with his/her testimony or that of his/her witness(es).

F. Record of the Hearing.--The HO makes a record of the hearing. In most cases, the hearing will be tape recorded. For both in-person and telephone hearings, the HO is responsible for making certain that a clear and audible tape recording is made of the hearing. In rare cases, the hearing will be recorded by other means. A typewritten copy may sometimes be made of the hearing.

Ordinarily, there will be little reason to go off the record. It may be desirable to do so for clarification, simplification, or to eliminate discussion on a matter that is not in dispute. The record is to include an explanation for going off the record if this procedure is used.

When directed by an ALJ, the Departmental Appeals Board, or CMS, the HO or you should arrange for reproduction of copies of the hearing testimony and other documentary evidence.

When the RO requests a copy of the record of the hearing for sample review purposes, the carrier will provide a copy of the tape of the hearing (or a transcript, at the RO's request).

If the appellant or his/her representative requests a copy of the tape recording of the hearing record, the HO provides a duplicate cassette. The appellant may request a transcript of the hearing (even though the hearing was recorded on tape). The appellant must pay the cost of transcribing the tape recording of the hearing. Waive the cost if it will cost $25.00 or less to provide a copy of the tape or to transcribe the hearing. Charge the full amount if it will cost more than $25.00. (See 42 CFR §405.833 - Record of carrier hearing.)

G. Continuance of Hearing.--The following items may warrant a continuance:

- Evidence (e.g., certain testimony or a document) submitted at the hearing has taken the appellant or other party by surprise, is adverse to his/her interests, and presents evidence that he/she could not reasonably have anticipated and is not prepared to meet;

- The HO expands the scope of the issues and either the appellant, another party or the HO needs to obtain additional evidence;

- New and material evidence is submitted during the hearing, and the HO and/or a party wants the opportunity to examine and evaluate it and respond, if appropriate; or,

- When the appellant is a physician or supplier, there has been a limitation on liability determination pursuant to §1879 of the Act, and the issue of whether the beneficiary knew or should have known that the item or service would not be covered is alleged by the physician or supplier, then the beneficiary must be notified of the physician or suppliers request for hearing and given an opportunity to respond to the issue.

If the affected party requests a continuance so that he/she may present additional oral testimony, the HO may grant the request unless other available means of rebuttal are clearly adequate. The HO continues the hearing if he/she discovers the need for testimony from an absent witness who would be available at another time.

H. Closing the Hearing.--At the close of the hearing, the HO advises the participants that he/she will write a decision setting forth his/her findings of fact and rationale for the decision, and that he/she will send a copy to each party and his/her representative. The HO further explains that he/she will not make a decision at the hearing.

The HO then asks whether there is or will be further evidence to be presented, and whether the appellant and other parties will want to examine any evidence that may be received. If there is no response, the HO states that the hearing is closed.

If there is further evidence to be presented, the HO may leave the record open until after he/she receives it. The documents should be submitted as soon as possible, but no later than the date set by the HO. The further evidence may also be faxed at the discretion of the HO. If necessary, request that the information be mailed to you.

If, after the hearing is over but before the HO makes a decision, he/she receives additional evidence that could affect the decision to the disadvantage of any of the parties, the HO must give the affected party an opportunity to review and respond to the evidence. If the new evidence does not adversely affect any of the parties, the HO must still determine whether to reevaluate his/her hearing decision based on this evidence.

12019.7 The HO Hearing Decision Timeliness.--Ninety percent (90%) of all HO hearing decisions must be issued within 120 days of receipt of the request for HO hearing (the 120 days starts on the date of receipt of the request in the corporate mail room). (See §1842(b)(2)(B)(ii) of the Act.)

The HO schedules hearings to meet the above timely processing requirement. As soon as practicable, but no later than 30 days after the hearing, the HO issues a decision based on the record developed at the hearing.

A. Evidence Submitted After the Hearing.--Any evidence received after the hearing is held but prior to issuing the hearing decision should be considered by the HO (and may be considered by you). Should the HO receive the evidence after the decision is issued, and the amount in controversy is less than $500 or the period for filing a request for ALJ hearing has expired, the HO may reopen his/her decision (provided the conditions for reopening are met). Otherwise, the HO advises the appellant that further appeal is to the ALJ level. If an ALJ hearing has been requested, the HO does not retain jurisdiction and may not reopen the case.

B. Limitations.--In accordance with regulations, the HO's decision is binding upon all parties to the hearing unless it is reopened and revised by the HO, or appealed to an ALJ. However, the HO's decision is not a precedent decision and does not affect subsequent hearing decisions or alter your payment determinations on other claims.

C. Copies.--You or the HO mails the decision letter to the last known address of each party and authorized representative. You or the HO retains a copy for the hearing file.

D. Letterhead for Written Correspondence.--The HO must follow the instructions issued by CMS for contractor letterhead written correspondence requirements unless otherwise instructed and/or agreed to by CMS.

All HO’s (including contractual and consultants) must use your letterhead for all notices and correspondence, including the hearing decision, and the letterhead must meet the letterhead written correspondence requirements referenced above. In addition, all notices, decision letters, etc., must state that the HO is an authorized HO for the carrier (include the name of the carrier in this statement). This statement can be added as part of the decision letter, and does not have to be pre-printed onto the letterhead itself.

E. Model Format And Required Elements For HO Hearing Decision.--Use the following format and standard language paragraphs, as applicable.

Italicized "*NOTE*s" are informational for you, and are not to be included in the decision letter itself.

Information contained in brackets ([which are underlined]) is to assist you with specific information that must be added to the letter for each hearing decision.

- Bullet items contain guidance to assist you with the content that will be specific and unique for each hearing decision. The guidance contained in the bullet items should also be removed from the decision letter itself.

CMS alpha representation

MEDICARE
PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

This is your MEDICARE PART B Hearing Officer HEARING DECISION

Date

Appellant's Name
Appellant's Address
Appellant's Party Status (either beneficiary, physician, or supplier)

RE:
Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Physician/Supplier Name:
Date(s) of Service:
Type(s) of Service:
Hearing Case No.:

NOTE: Use one of the following:

This decision is **FULLY FAVORABLE**. You will receive a(n) [Explanation of Your Medicare Part B Benefits/Medicare Summary Notice/Remittance Advice] within [estimated time frame]. Please see below regarding further appeal rights.

OR

This decision is **PARTIALLY FAVORABLE**. You will receive a(n) [Explanation of Your Medicare Part B Benefits/Medicare Summary Notice/Remittance Advice] within [estimated time frame]. Please see below regarding further appeal rights. [If beneficiary is the appellant add a statement about financial liability.]

OR

This decision is **UNFAVORABLE.** Please see below regarding further appeal rights. The amount remaining in controversy is:_____. [If beneficiary is the appellant add a statement about financial liability.]

Dear [Name of Appellant]:

NOTE: Introductory paragraph should include:

- Type of hearing held, when and where;
- For telephone and in-person hearings, state who was present (if different from those testifying) and who testified;
- Statement that the decision was made and on what basis, e.g., "This letter contains my decision based on...".

FACTS:

- Include all the relevant factual data that was part of the file prior to the hearing. This can include, but is not limited to:
  - One sentence summary statement of the beneficiary's diagnoses (disease, ailment, etc.) for which the service/supply in question is being heard, if relevant to the decision.
  - Brief mention of related events or history considered to be relevant to the decision in the case.
  - Other relevant factual data bearing on the decision, including the date(s) and type(s) of service (or supply purchased); stated reason for initial determination; and date of carrier review and the resulting determination; mention of relevant testimony and/or documents provided.
  - Clear explanation of the actual amount of money allowed or adjusted.

ISSUE(S):

- The issue(s) should be specific to the case rather than generic (i.e., identify the beneficiary, the provider and the specific service/supply as appropriate). The issue(s) statement should be stated as a question. For example, Was _____(the service or item/supply received) covered under Part B of Medicare?; or, What is the appropriate allowed amount for _____(the services or items/supplies)?

- For all claims where assignment has been taken and the denial is based upon §1862(a)(1) or (a)(9) or §1879(g), limitation on liability under §1879 of the Act is a consideration and must be addressed separately. (See MCM, §§7300ff.) Keep in mind that §1986(a)(1) denials are generally "medically reasonable and necessary" denials, but this section also includes other types of denials, such as denials for screening mammographies or screening pap smears when the number of tests performed in a given time period exceeds the frequency standards.

- For cases involving overpayments, §1870 of the Act (i.e., waiver of recovery of overpayments) must be addressed as a separate issue. (See MCM, §§7100ff.) If applicable, §1879 issues must be addressed first.

- For cases involving physician refund issues, §1842(l)(1) of the Act must be addressed. (See MCM, §§7300ff and 7500ff.)

- In multi-issue cases, each issue for which a decision is made should be completely discussed before proceeding to the decision on the next issue.

DECISION:

- A direct and unequivocal statement of the Hearing Officer's decision. It should answer the question(s) asked under the **ISSUE(S)** section, above.

RATIONALE:

- Give a narrative description of the logic that led the HO to make the decision. Note again that statements such as “not medically reasonable and necessary under Medicare guidelines” or “Medicare does not pay for X” are conclusive in nature, and are not sufficient.

- The rationale may include, but is not restricted to:

  - Appellant's allegation, if any, constituting the reason for the hearing request, e.g., "You have alleged that the DME supplier did not inform you that the seat-lift chair may not be covered for Medicare payment."

- Citations of the statutes, regulations, CMS rulings, national coverage decisions, Medicare Carriers Manual (MCM) and local or regional medical review policies relevant to and surrounding the subject matter and issues involved in the hearing. When using MCM language be sure it supplements a previously cited statute/regulation/coverage decision/ruling reference.

- Narrative description of how these statutes, regulations, etc., relate to the specific case.

- References to statutes, regulations, CMS rulings and national coverage decisions, should be case specific and should supplement or support the basis for the decision. For example, if the issue is home use oxygen, and the reason for denial is that the condition is angina pectoris, with no hypoxemia, the letter does not have to quote the whole §60-4 of the Coverage Issues Manual. The reference might simply state that, "CMS will not cover home use oxygen for angina pectoris in the absence of hypoxemia (§60-4 of the Coverage Issues Manual)."

- Other information that is relevant to support the decision in the case.

FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE HEARING

If you are satisfied with this decision, you do not need to take further action. If you are not satisfied with this decision, and you meet the requirements for requesting an Administrative Law Judge hearing, you must act quickly to appeal.

The law requires that at least $500 remain in controversy for you to appeal this decision to the Administrative Law Judge (or ALJ) hearing AND that your request for ALJ hearing be made within 60 days after your receipt of this decision.

If less than $500 remains in question, you may be able to combine the claim or claims that are the subject of this HO decision with claims from other recently issued HO decisions you have received (or may receive) to meet the $500 amount remaining in controversy requirement. This is called "aggregating claims" and more information is provided below.

You or your authorized representative (if you have appointed a representative) may write to request an ALJ hearing.

If you qualify for, and wish to request an ALJ hearing, you can request an ALJ hearing by writing to this office at the address below, to any CMS office, or to any Social Security Office within 60 days after you receive this decision. A qualified Railroad Retirement Board beneficiary may send a request for ALJ hearing to an office of the Railroad Retirement Board. Although you may include additional evidence with your request for an ALJ hearing, you may also present evidence supporting your claim at the ALJ hearing itself.

Insert Your Address Here

YOUR AMOUNT IN CONTROVERSY: (If the appeal involves claims that were previously denied and are now found to be covered/medically reasonable and necessary, the HO's decision should use language along the following lines.)

As indicated above, the following claim(s) will be paid by Medicare (indicate claim control number(s) or date(s) of service): _____. You will be notified of the specific payment amount separately. The following claim(s) will not be paid by Medicare (indicate claim control number(s) or dates of service):_____.
The amount that remains in controversy for this/these claim(s) is **$_____.**

NOTE: The language in the above bullet will need to be modified if coverage is at issue for some of the claims involved in the appeal while the amount of payment is at issue for other claims involved in the appeal. In determination letters to beneficiaries where the physician/supplier has aggregated claims involving numerous different beneficiaries, do not include this section.

RULES FOR AGGREGATING CLAIMS:

To "aggregate claims" each claim included in your request for ALJ hearing must be appealed within 60 days from the date the HO decision was issued on the claim, and each claim must have already received a HO hearing decision.

If you want to request an ALJ hearing by combining the amounts remaining in controversy from other claims, you must state on your request for ALJ hearing that you are "aggregating claims," and you must list the claims on your request.

A party may aggregate claims to meet the $500 amount remaining in controversy requirement for an Administrative Law Judge hearing in one or more of the following ways:

1. An individual beneficiary may combine claims from two or more physicians or suppliers to meet the amount remaining in controversy requirement IF each claim has had a HO hearing decision issued AND the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;

2. An individual physician or supplier may combine claims from two or more beneficiaries to meet the amount remaining in controversy requirement IF each claim has had a HO hearing decision issued AND the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;

3. Two or more beneficiaries may combine their claims for services received from either the same or different physician or supplier IF the claims involve common issues of law and fact, AND, each of the claims has had a HO hearing decision issued, AND, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;

4. Two or more physicians or suppliers may combine their claims IF the claims involve the delivery of similar or related services to the same beneficiary, AND, each of the claims has had a HO hearing decision issued, AND, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request; or,

5. Two or more physicians or suppliers may combine their claims IF the claims involve common issues of law and fact for services furnished to two or more beneficiaries, AND, each of the claims has had a HO hearing decision issued, AND, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request.

The Administrative Law Judge is responsible for deciding what are "common issues of law and fact" and what are "similar or related services." You may wish to include in your request for Administrative Law Judge hearing an explanation of why you think the claims that you have combined seem to involve either "common issues of law and fact" or why the claims are for "similar or related services."

HELP WITH YOUR APPEAL:

- If the appellant is the beneficiary, insert the following paragraphs:

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify.

In addition, volunteers at Medicare peer counseling programs in your area can also help you. If you would like more information on how to get in touch with a counselor, please contact [name and address of carrier] or call 1-800-MEDICARE.

- If the appellant is anyone other than the beneficiary and the decision is partially or wholly unfavorable, insert the following paragraph:

If you want help with your appeal, there are groups, such as legal aid services, that will provide free advisory services if you qualify.

- If you are issuing a preliminary on-the-record decision, but an in-person or telephone hearing was requested, insert the following:

We guarantee you the hearing of your choice. However, first we prepare a decision based on the record because many appeals can be resolved this way. If you still want an in-person or telephone hearing, please use the enclosed pre-addressed postcard to indicate your choice. Please complete, sign and date this postcard in the spaces shown, and return the postcard within 14 days.

If you wish to go forward with an in-person or telephone hearing, a new Hearing Officer will conduct the hearing. I will have no influence on the new decision. You or your representative will be able to provide information before, and submit additional evidence to, the new Hearing Officer.

- For all hearing decisions, conclude with the following:

This decision applies only to the services and circumstances I considered on the claim(s) in question. If you want copies of the applicable statute, regulations and/or CMS Coverage Manual sections used in this decision, please let me know. Please attach a copy of this letter to your request. If you need more information or have any questions regarding your case, please contact me at the above address.

Sincerely,

[Name of Hearing Officer]
Medicare Hearing Officer

cc:
Beneficiary
- Send copy to beneficiary if the appellant was the physician or supplier.
- Protect beneficiary privacy if the case involves multiple beneficiaries.

Representative
- As applicable, of beneficiary and/or of physician or supplier.

Physician/Supplier
- As applicable, if appellant was the beneficiary and the physician/supplier has appeal rights or refund obligations.

12020. EFFECTUATION OF HO HEARING DECISIONS

12020.1 General Rule.--Effectuate 90 percent of HO hearing decisions within 15 calendar days of the date of the decision, and effectuate 100 percent within 30 calendar days of the date of the decision. "Effectuate" for purposes of this section means for you to complete the necessary system input(s) relative to complying with the decision (e.g., adjustment is entered into your claims processing system).

12020.2 Delaying Effectuation.--If you (which includes staff from the medical review unit, fraud unit, overpayments unit, etc.) believe that an HO's decision on a particular case is incorrect due to an error in interpretation of statue, regulation, manual, etc., you may ask the HO to reopen his/her decision. This is subject to the time limits and other parameters established by regulations and these instructions, below, and in §12100. If an ALJ hearing has been requested, the HO does not retain jurisdiction and may not reopen the case.

It is not sufficient grounds for requesting a reopening if you simply disagree with the conclusion reached by the HO, but cannot show a legally supportable basis for your disagreement. Reopening is not to be pursued in situations where persons could reasonably reach different conclusions based on the evidence in the case file. If you are confused, you may consult the RO for advice on whether a reopening is necessary.

NOTE: If the HO has dismissed a request for HO hearing, you may ask the HO to vacate his/her dismissal order.

12020.3 Elements of Written Request for Reopening.--You must provide a copy of your request for reopening to the head of the hearings department, or such unit in your contractor that oversees the Hearing Officer hearing function. The request itself must state the specific grounds on which you believe that the HO's decision is incorrect. This could include citations to applicable statutes, regulations, CMS rulings, national coverage determinations, MCM instructions, and local or regional medical review policies issued by you.

12020.4 Notice to Parties of Reopening Request.--You must provide written notice to all parties to the HO decision that you have asked the HO to reopen the HO decision. (See 42 CFR §405.842 – Notice of reopening and revision.)

12020.5 HO Reply to Reopening Request.--If the HO determines that a revised HO hearing decision is necessary, based upon the reopening authority instructions contained in §12100, then he/she must issue such revised HO hearing decision within 30 calendar days of receipt of the written request for reopening. The revised HO hearing decision is sent to all parties. In the case of a revised HO hearing decision, all parties have the right to request an ALJ hearing if they are not satisfied with the revised HO hearing decision and if they meet all requirements for requesting ALJ hearing.

If the HO determines that revision of the HO hearing decision is not appropriate, based upon the reopening authority instructions contained in §12100, then he/she must advise you in writing within 15 days of receipt of the written request for reopening.

12020.6 Notice to Parties of HO Determinations.--If the HO issues a revised HO hearing decision, it is sent to the parties. If the HO determines that he/she will not revise the hearing decision, the HO must advise all parties in writing that the HO hearing decision has not been revised.

12026. REQUESTS FOR PART B ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

If a party to the HO hearing is dissatisfied with the HO's hearing decision and the amount remaining in controversy is $500 or more, the party is entitled to a hearing before an Administrative Law Judge (ALJ). (See 42 CFR §405.815 – Amount in controversy for carrier hearing, ALJ hearing and judicial review.) This function is currently performed by ALJs employed by the Social Security Administration's Office of Hearings and Appeals (SSA/OHA). The ALJ hearing results in a new decision by an independent reviewer.

12026.1 Right to Part B ALJ Hearing.--To receive an ALJ hearing, the party must file a written request for a Part B ALJ hearing with you, at an office of the RRB (in the case of a qualified RRB beneficiary), or with CMS, or at an office of the SSA, within 60 days of the date of his/her receipt of the HO's decision. It is presumed that the appellant received the HO's decision within 5 days of the date of the HO's decision, unless there is a reasonable showing by the appellant to the contrary.

For the convenience of parties, CMS provides a form that may be used to request a Medicare Part B ALJ hearing. Provide copies of the form to parties upon request. (See Exhibit 4: Request for Part B Medicare Hearing by an ALJ (Form CMS-5011B).) It is not necessary, however, that this form be used to make a written request.

12026.2 Forwarding Requests to SSA/OHA.--Requests for Part B ALJ hearings are forwarded with the case file to the "SSA/OHA Division of Medicare - Part B" (formerly known as the "Medicare Part B Development Center") at the address below. Only the ALJ or the DAB has the authority to dismiss a request for ALJ hearing. This applies even when it appears that the request does not meet the jurisdictional requirements for requesting an ALJ hearing (e.g., the amount remaining in controversy or timely filing requirements do not appear to have been met).

However, if all prior levels of appeal have not been exhausted (i.e., either a HO hearing or a review has not been conducted), treat the request for ALJ hearing as a request for HO hearing or for review and process the appeal request.

A. Address for Office of Hearings and Appeals.--Requests for Part B ALJ hearing must be forwarded, along with the case file (see below for the case file requirements), to:

SSA/Office of Hearings and Appeals
Division of Medicare-Part B
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

Phone inquiries about the status of a request for Part B ALJ hearing should be directed to:

Division of Medicare - Part B
(703) 605-8550

B. Time Limit for Forwarding.--Forward a request for Part B ALJ hearing, along with the appeals case file, within 21 calendar days of your receipt of the request in the corporate mail room. For aggregated cases which exceed 40 beneficiaries, forward the case file within 45 calendar days.

C. Implied Requests for ALJ Hearings.--Sometimes appellants will send a letter to you after a hearing officer hearing expressing their dissatisfaction with the hearing results, but do not clearly state that they are requesting an ALJ hearing. In this instance, you must contact the appellant and clarify whether he/she wishes to request an ALJ hearing. Inform the appellant of what he/she needs to do to request an ALJ hearing.

12026.3 Case File Preparation.--The documents in the case file should be arranged in the order indicated below. Place any additional documentation in the case file prior to forwarding the file to SSA/OHA. Confirm that all applicable documents listed on the case file summary sheet are included in the case file, or if not included, that the case file summary sheet indicates that the document was not received. You may include your analysis of why the request does not meet the jurisdictional requirements for requesting a Part B ALJ hearing. This may be included in a cover sheet or other transmittal document submitted with the case file.

Do not modify the order that documents appear on the exhibit list, and use tabs for where each exhibit would appear, even if it is not available for the file. Behind each tab, place the exhibit, or, where the exhibit does not exist, a statement saying that the exhibit is missing or was not provided by either the carrier or the physician or other supplier, as appropriate. Include a statement that "these are the complete records submitted to Medicare from the physician or other supplier as of this date _____," and place this on top of the medical records and behind the appropriate tab.

Use a standard 9"x 12" folder or accordion folder. Attach the entire case file to the right side of the folder. Leave the left side empty.

As resources allow, make a folder for each beneficiary or for each claim at issue with all of the information (documentation, relevant regulations, contractor instructions, rulings, etc.) contained in that folder. This becomes important when an ALJ or the DAB either makes a determination or issues a remand order on some, but not all, of the claims in an appeal. This ensures that information on each claim stays with the claim/appeal.

Include in the case file a Contacts List identifying which unit(s) within the carrier originally worked on the case (e.g., medical review, fraud and abuse, overpayments, Medicare secondary payer, etc.) and list the name, phone number, fax number, and e-mail address of staff in these unit(s) who can be contacted for further information. List your web-site along with other useful web-sites (e.g., CMS.HHS.gov, SSA.gov, HHS.gov). Finally, as appropriate, you may include a list of expert witnesses in the geographic area who are available to testify.

Send all information together in one package. Avoid sending information in piecemeal to OHA. It is very difficult for OHA to track down to whom the files have been sent and therefore cannot associate documentation that comes in late or in separate envelopes with the original case file. When a case involves multiple boxes, number them as part of a set (i.e., box 1 of 5, box 2 of 5, etc.)

A. Documents in the Appeals Case File.--The case file must contain the items listed below, arranged in descending date order (i.e., earliest on bottom and most recent on top with all procedural documents preceding all medical documents). Form CMS-3509 (version 12/99 or more current) must be placed on front cover of the case file. Disregard earlier versions of this form. Aggregated cases containing 30 beneficiaries or more and $40,000 or more in controversy (considered "big box cases") are assembled using a **Primary File** as described below.

NOTE: For applicable items, send originals and retain copies for your records. If you are unable to send the original documents, send copies along with a letter on contractor letterhead and signed by a manager certifying that the copies are true facsimiles of the original documents.

Procedural Documents

- Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- Explanation of Your Medicare Benefits (EOMB)/Medicare Summary Notice (MSN)/ Remittance Advise (RA) (facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- Review request;
- Review determination;
- Hearing Officer (HO) hearing request, if applicable;
- HO hearing decision, if applicable;
- Original request for Part A or Part B ALJ hearing [including envelope or image of the envelope]; and
- Appointment of representative form (Form CMS-1696-U4 or SSA-1696-U4) or other written authorization, if applicable;

Medical Documents

- Medical records, separated by facility or doctor in chronological order (most recent on top);
- Referral to/from your medical staff, with professional qualifications of the reviewer noted in the document, if applicable;
- Copies of carrier, intermediary, program safeguard local medical review policies, or regional medical review policies upon which the HO relied, if applicable;
- Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, newsletters, any other information used to make a determination; and
- Any other exhibits that you consider important for the ALJ to consider (e.g., some cases will involve fee schedule information, some will have tape-recorded hearings).

B. Case File Assembly for "Big Box Cases".--For aggregated requests filed by a physician or other supplier that involve 30 beneficiaries or more and $40,000 or more in controversy, organize the case file in the following manner:

1. Create a **Primary File** (sometimes referred to a master file) using all the documentation that is common to all the aggregated claims. Clearly identify on the file cover that it is the Primary File.. This information in this file should include:

- Copies of carrier, intermediary, program safeguard local medical review policies, or regional medical review policies upon which the HO relied;
- Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, newsletters, any other information used to make a determination;
- Hearing Officer (HO) hearing request, if the same for all beneficiaries;
- HO hearing decision, if the same for all beneficiaries;
- Request for Part A or Part B ALJ hearing including envelope; and
- Tape of fair hearing in labeled envelope with identifying information stapled securely to the inner left hand side of the file, if applicable.

The Primary File number should correspond with the HIC number of the first case in the group of aggregated claims organized alphabetically by beneficiary last name. Place this beneficiary's individual claim information, as described below, in this folder preceding the information that is common to all aggregated cases. Separate this information with a tab or blank sheet of paper. Label tab or blank sheet of paper with the full name of the beneficiary, Medicare health insurance claim (HIC) number, and date(s) of service involved.

Form CMS-3509 (version 12/99 or more current) must be placed on front cover of the case file. Place a list of all the aggregated cases on top of the documents located in the primary file.

2. Create **individual claim folders** using all the documentation that is specific to each individual beneficiary. In creating individual claim folders you should adhere to the following guidelines:

- Separate medical documents for each beneficiary into separate folders. If the documentation is minimal, you may use tabs to separate the documentation.
- Label each folder cover or tab with the name of the beneficiary. Include the beneficiary's full name, Medicare health insurance claim (HIC) number, and date(s) of service involved on the folder cover or sheet of paper.
- Identify the Primary File on the folder cover or sheet of paper.
- Organize the medical documents for each beneficiary in descending date order (i.e., earliest on the bottom and most recent on the top).
- Organize the aggregated cases alphabetically by beneficiary last name.
- Provide a complete set of procedural documents for each beneficiary excluding any documentation that is common for all the aggregated cases (e.g., if the same hearing decision and laws apply for all beneficiaries in the case, include only one set in the master file).
- Make sure each individual beneficiary folder in the "big box case" makes reference to and identifies the Primary File to which it is associated.

The individual folders must contain **all** the procedural and medical documents listed and be organized in the same order as described above in subsection (A), excluding any of the documents that are common to all the aggregated cases.

NOTE: Subsequent adjudicators do not have access to the fee schedule database. The HO that relied upon this database in making his/her decision should either include a copy in the case file, or be ready to produce it upon request by any subsequent adjudicator.

C. Assembling the File.--Assemble the file in the following manner:

- Use a standard 9" x 12" folder or accordion folder. If a tape of the hearing is included, place it in an envelope, label the envelope with identifying information, and staple the envelope securely to the inner left hand side of the folder;
- For aggregated requests filed by a beneficiary, keep the documents relating to treatment from each physician or supplier together. Separate the documents relating to each physician or supplier by a blank sheet of paper;
- Group procedural and medical documents together in chronological order. (Most recent on top and earliest on bottom.); and
- Attach the most current version of Form CMS-3509 to the front cover of the file.

D. Requests for Information.--It is within the authority of an ALJ to request your input, or to request documentation from you. If you are invited to attend and/or testify, or to submit additional information, at an ALJ hearing, do so (as your resources allow). Work with all your interested staff (e.g., medical review, fraud and abuse, overpayments, etc.) to provide additional documentation, witnesses, etc., in response to the request. If you have any questions regarding your participation, contact your regional office for guidance. However, you may not disregard a subpoena issued by an ALJ, unless otherwise instructed by CMS CO or RO.

12026.4 Acknowledgment of Request for Part B ALJ Hearings.--Acknowledge the appellant's request for ALJ hearing by sending him/her a letter that utilizes the format and standard paragraphs contained in §12026.5, below, within 30 calendar days of your receipt of the request in your corporate mail room.

12026.5 Model Format for Acknowledgment of ALJ Hearing Request.--

CMS alpha representation

MEDICARE
PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

Date

Appellant's Name
Appellant's Address
Appellant's Party Status (either beneficiary, physician, or supplier)

RE:
Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Physician/Supplier Name:
Physician/Supplier Medicare Number:
Date(s) of service:
Type(s) of Service:
Hearing Case No.:

Dear (Name of Appellant):

We have received your request dated [date of ALJ hearing request] for a Part B administrative law judge (ALJ) hearing. We are forwarding your file to the Social Security Administration's Office of Hearings and Appeals (SSA/OHA) in Falls Church, VA, for processing. SSA/OHA will assign an ALJ to your case who will then contact you regarding the time and date of your ALJ hearing. If you have any questions about your request, you may contact SSA/OHA directly at: (703) 605-8550.

Or you may write to SSA at the following address:

SSA/Office of Hearings and Appeals
Division of Medicare-Part B
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

If there is anything else that I can help you with, please do not hesitate to call me at [phone number at carrier].

Sincerely,

[Name of Contact Person at Carrier]

cc:
Representative [if applicable]
Beneficiary [if appellant is the physician or supplier; be sure to protect beneficiary privacy if the case involves multiple beneficiaries]
Physician/Supplier [if appellant is the beneficiary and the physician/supplier has appeal rights]

12028. EFFECTUATION OF PART B ADMINISTRATIVE LAW JUDGE (ALJ) DECISIONS/DISMISSALS

The ALJ will either: (1) issue a decision based on the request for Part B ALJ hearing; or, (2) issue an order of dismissal of the appellant's request for Part B ALJ hearing.

You are required to review each ALJ decision in a timely manner in order to determine whether there are effectuation responsibilities. As part of this review, you are to identify those ALJ decisions and dismissals that meet the guidelines for recommending agency referral (formerly known as the Protest Process). Your responsibilities relative to recommending agency referral are contained in §12029, below.

12028.1 Review and Effectuation of ALJ Decisions - General.--In many cases, the ALJ's decision will require an effectuation action on your part. Do not effectuate based on correspondence from any party of the hearing. Take an effectuation action only in response to a formal decision. "Effectuate", for purposes of this section, means for you to complete the necessary action relative to complying with the decision. In most cases, it will be clear what action is required in order to effectuate the ALJ's decision. If it is not clear, or you cannot determine how to effectuate the decision, contact you RO for guidance. As necessary, your RO may send a letter to the ALJ asking for clarification on how to effectuate the decision. If a clarification from the ALJ is necessary, you should consider the clarification the final determination for purposes of effectuation. If effectuation of a favorable or partially favorable determination will be delayed, advise the appellant that a clarification of the ALJ decision has been requested.

Some ALJ decisions will be straightforward and effectuation will be relatively simple. For others, the decision may require extensive research on your part. Remember that when effectuating an ALJ's decision, you are to use the payment policies in effect on the date the claim was first submitted for processing, unless specifically directed otherwise.

12028.2 Effectuation Time Limits.--

A. No Agency Referral.--If the ALJ decision is favorable to the appellant, gives a specific amount to be paid, and there is no agency referral to the DAB, effectuate within 30 days of receipt of the ALJ decision. If the decision is favorable and no agency referral is made, but the amount must be computed by you, effectuate the decision within 30 days after you compute 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 ALJ decision. If the decision is unfavorable to the appellant and there is no agency referral, effectuate within 30 days after the 60-day time limit for parties to request DAB review.

B. Agency Referral.--Where CMS submitted an agency referral to the DAB, do not effectuate until 30 days of the DAB decision or when advised by the RO, whichever is sooner.

1. Where DAB accepts agency referral for review, you will be advised by CMS to delay effectuation until DAB takes further action.

2. Where DAB declines to review agency referral, you will be advised by CMS to effectuate the decision.

12028.3 ALJ Data Extraction Form.--Complete the Data Extraction Form and return the completed form promptly to the contractor that CMS uses to enter and maintain ALJ data.

12028.4 Misrouted ALJ Case Files.--There may be times when you receive a case file or ALJ decision that has been misrouted to you. If you receive a case file that does not belong to you, forward the case file back to the ALJ clearinghouse (the contractor who has responsibility for tracking ALJ cases). Send a transmittal letter along with the case file stating that the case file has been misrouted to you. List any easily identifiable information on the transmittal sheet, such as the docket number. Send a copy of the transmittal letter to the NY RO office at:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Beneficiaries, Health Plans and Providers
Attention: ALJ Decision Tracking
26 Federal Plaza, Room 3800
New York, New York 10278-0063

You may want to consider keeping a log of misrouted ALJ case files indicating the date received, date sent back to the ALJ clearinghouse, and any easily obtainable identifying information, such as the docket number, beneficiary name(s), provider name, service date(s), ALJ decision date, DCN, etc.

12028.5 Duplicate ALJ Decisions.--If you receive duplicate ALJ decisions on the same case, you must bring this to the attention of your RO and OHA immediately. In theses cases, the OHA will take the necessary steps to resolve the issue. For example, one ALJ may vacate his/her decision. Take the necessary steps to advise the appellant of your actions.

12029. RECOMMENDING AGENCY REFERRAL OF PART B ALJ DECISIONS OR DISMISSALS TO THE CMS RO (FORMERLY KNOWN AS THE AGENCY PROTEST PROCESS)

The process of CMS recommending agency referral of a Part B ALJ decision or dismissal to the DAB is initiated by you or by CMS. If you determine that an ALJ's decision/dismissal should be forwarded to the DAB, prepare a draft Memorandum of Agency Referral and forward to the CMS RO.

12029.1 Time Limits for Forwarding Agency Referral Memorandum to CMS RO.--You have 30 days from the date of the ALJ decision/dismissal to review the ALJ decision or dismissal, develop the recommended agency referral memorandum, and forward the draft memorandum and case file to the lead CMS RO for your region. The lead RO may grant an extension to you of the 30-day timeframe on a case-by-case basis. However, the RO must get agency referral to the DAB by the 40th day.

NOTE: Problems concerning time limitations, or non-receipt of case files, should be brought to the attention of your RO in a memorandum separate from any recommended agency referral.

12029.2 Guidelines for Reviewing ALJ Decisions/Dismissals.--The DAB may review an ALJ's decision/dismissal if there was an error of law; the ALJ's decision/dismissal was not supported by substantial evidence; the ALJ abused his/her discretion; or there is a broad policy or procedural issue that may affect the general public. This could include an LMRP or RMRP that is well supported by the medical standards and practice in your jurisdiction but which the ALJ has disregarded for

insufficient reasons or without explanation. ALJs are required to follow the Act and applicable regulations issued thereunder, CMS rulings, and all national coverage decisions based on §1862(a)(1) which have been published in either a CMS manual or the **Federal Registe**r.

NOTE: In order to assist in the review of ALJ decisions by the DAB, material (i.e., the decision and case file) for decisions not favorable to the appellant or cases dismissed by the ALJ will be held for 120 days by a CMS designated contractor. If the appellant requests a DAB review, the DAB will request that the contractor forward the material to it. If, after 120 days, the DAB has not requested any material, it will be forwarded to you.

12029.3 Draft Agency Referral Memorandum Content.--If you are dissatisfied with a Part B ALJ decision, or with the ALJ's order of dismissal, you should suggest to the lead RO that the decision/dismissal be referred to the DAB. The agency referral memorandum should clearly set out the reasons why (1) there appears to be an abuse of discretion by the ALJ, (2) there is an error of law, (3) the action, findings or conclusions of the ALJ are not supported by substantial evidence, or (4) there is a broad policy or procedural issue that may affect the general public interest.

Do not reference the regulations that govern the DAB taking own motion review. Write the memorandum using a formal tone and avoid using confrontational or accusatory language.

The DAB will consider new and material evidence if it relates to the period on or before the date of the ALJ decision or dismissal. If new and material evidence is submitted, the DAB will consider the additional evidence only where it relates to the period on or before the date of the ALJ's decision or dismissal.

Do not include complaints concerning the time limitations for submission of agency referrals or of non-receipt of ALJ decisions/dismissals or case files in the draft memorandum.

Each memorandum should name only one beneficiary, unless the ALJ decision or dismissal lists more than one name. Use care to ensure the privacy of each beneficiary. If the RO submits the agency referral memorandum to the DAB, a copy of the agency referral memorandum is sent by the RO to all parties to the appeal. To comply with privacy requirements, a general memorandum can be prepared, and you can attach a list of beneficiaries. The RO will then be able to send a separate letter with the memorandum to each beneficiary.

12029.4 Draft Memorandum Format.--Use the following format and guidelines for the memorandum you send to the lead RO:

Date _____

From _____

Subject Recommended Agency Referral of Medicare Part B ALJ Decision Dated _____

To CMS Regional Office

Refer to

Beneficiary:
HIC No.:
Docket No.:
Physician or Other Supplier:
Processing Carrier/DMERC:
Date of ALJ Decision:

Summary: This ALJ decision or dismissal is recommended for agency referral because _____
_____
_____.

The basis for recommending agency referral is:_____
_____
_____.

Include the Signature, Date, and Title of person submitting memorandum to RO at the end of the memorandum.

12029.5 Submission of Draft Agency Referral Memorandum to CMS RO.--Send the draft memorandum and case file to the lead RO within the time limits discussed above. The Dallas RO has the lead for submitting agency referrals for the Dallas region. The Atlanta RO has the lead for submitting agency referrals for the Atlanta region. The New York RO has the lead for submitting agency referrals for the other eight regions. The CMS region with oversight of you is a valuable resource for helping you determine whether to recommend agency referral of an ALJ decision or dismissal, and should be utilized.

If CMS sends the agency referral to the DAB, the RO will send a copy of the memorandum (including any attachments) to the following:

- The beneficiary (or their estate)
- The beneficiary's representative, if applicable
- The physician or other supplier providing the item or service
- The servicing carrier
- Anyone else to whom the ALJ issued a copy of the decision or dismissal
- The CMS Central Office appeals area

12032. EFFECTUATION OF DAB ORDERS AND DECISIONS

12032.1 Background.--The level of administrative review available to parties after the Part B ALJ hearing decision or dismissal order has been issued, but before judicial review is available, is Departmental Appeals Board (DAB) review. The DAB reviews requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs. (See 42 CFR §405.856.)

12032.2 Requests for Case Files.--When the DAB 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 DAB will request all case files from the specialty contractor who has responsibility to receive and store the files sent by ALJs following their decisions. In some cases, where the file is not available from this contractor, the DAB must then determine which Medicare contractor has the case file and must then ask that contractor to forward the case file to the DAB. You must comply with the DAB's request for the case file, supplying the actual case file in the exact order and manner as you received it from SSA/OHA. Forward the requested case file within 21 days to the DAB. Be responsive to DAB requests. Maintain a log of all requests made by the DAB for case files, noting the date of the request, the manner in which it was made, the name of the contact, any identifying information given, and your response.

If you are unable to locate a case file that falls under your jurisdiction, you must recreate the case file within 60 days. If you determine that the case file does not fall under your jurisdiction, you must notify the DAB in writing within 14 calendar days, with a copy to your RO.

12032.3 Carrier Effectuation Responsibilities.--When you receive a decision from the DAB that requires effectuation on your part, initiate effectuation within 30 days of your receipt of the DAB decision, and complete effectuation within 60 days. Should you have any questions regarding effectuation, contact your RO for guidance.

12033. REQUEST FOR U.S. DISTRICT COURT REVIEW BY A PARTY

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision.

You cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court.

If you receive, either directly or by copy, a summons or complaint due to a party's request for U.S. District Court review, and it does not appear that a copy was sent to the following address:

General Counsel
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Send a copy to that address and notify your RO immediately.

12034. EFFECTUATION OF U.S. DISTRICT COURT DECISIONS

The U.S. District Court (hereinafter Court) may remand the case to the DAB or ALJ for further proceedings.

In rare cases, the court will issue an order that will require effectuation by you. In this situation, contact your CMS RO appeals contact for further instructions before taking any action.

12040. REVIEW AND ANALYSIS OF INITIAL DETERMINATIONS AND APPEALS DETERMINATIONS/DECISIONS AND DISMISSALS

12040.1 Introduction.--There are administrative costs associated with conducting each level of appeal, with the administrative cost of conducting an appeal increasing at each subsequent level. Therefore, you should try to resolve appeals at the lowest level possible. Establishing and maintaining a quality improvement program is an excellent educational tool to help you achieve the goal of identifying and eliminating unnecessary appeals. Such a tool can assist you in finding deficiencies in the appeals process and allowing you to take the necessary steps to correct them. This tool also allows you to provide feedback to other areas of the contractor, including provider education and program integrity. Eventually, this should result in a reduction in unnecessary appeals.

12040.2 Quality Improvement.--The results of the quality control check and internal feedback system should be communicated to employees affected (claims processing, medical review and professional relations staff), and should be used to enhance training efforts, both for carrier staff, physicians and other suppliers, and beneficiaries. The following are requirements that should enable you to employ an adequate quality improvement program.

- The capability to identify the reasons for full or partial reversals of initial determinations at the review level, based on a 10 percent or 100 per month (whichever is less) random sample of such reversals. Data for this sample may be collected either as the reviews are being performed, or at the end of the month.

- The capability to monitor 45 telephone reviews or 5 percent of telephone reviews per quarter, whichever is less, for accuracy, customer service, timeliness, and adherence to the Privacy Act as well as to ensure that appellants are informed of their rights to the next level of appeal if the decision is not fully favorable.

- The capability to identify physicians and other suppliers who have a high review request rate and whose initial claim determinations are frequently reversed at the review level. Use the results in the Provider Education Training Process for technical assistance to the physician or supplier, as appropriate.

- The capability to identify problems cited in correspondence and issues that are appealed more than the average.

- The capability to produce regular monthly reports on claims processing system errors with analysis on how these might affect review request rates. These errors should be corrected as soon as possible.

12040.3 Feedback.--You can develop and implement some type of feedback on review determinations, HO hearing decisions and dismissals, and ALJ decisions and dismissals, to the staff responsible for conducting the prior level of appeal. These procedures may include the following.

A. For Review Determinations.--Capability to identify the reasons for full or partial reversals of initial determinations at the review level, based on a 10 percent or 100 per month (whichever is less) random sample of such reversals. Data for this sample may be collected either as the reviews are being performed, or at the end of the month. Your analysis should focus on issues such as:

- Reversals resulting from initial claims processing errors;

- Reversals resulting from the submission of documentation that should have been submitted with the initial claim; and

- Physicians or other suppliers who submit a high volume of requests for review and whose initial claim denials are frequently reversed at the review level.

Send copies of the findings from analyzing the reversals to the managers of the claims processing units to be used in the claims examiner education and training process.

B. For HO Decisions.--Capability to identify the reason for full or partial reversals of review determinations at the HO hearing level. A 10 percent or 50 per month sample (whichever is less) of reversals will be sufficient. Your analysis should focus on issues such as:

- Reversals resulting from reviewer error;

- Physicians or other suppliers who submit a high volume of HO hearing requests and for whom initial and review determinations are frequently reversed at the HO hearing level; and

- Issues that are appealed more often than average and are usually reversed at the HO hearing level.

Send copies of the findings from analyzing the reversals to the manager of the review unit, to be used in the reviewer education training process and individual employee counseling.

C. For ALJ Decisions.--Develop the capability to identify the reason(s) for full or partial reversals and dismissals at the ALJ level and take corrective action. Your analysis should focus on issues such as:

- Reversals where it appears that the contractor hearing officer made an error;

- Reversals that reference §1879 of the Act as the reason for the reversal;

- Reversals that reference regulations found at 42 CFR as the reason for reversal;

- Reversals that deal with physical or occupational therapy, ambulance, dental, and DME; and

- Reversals from ALJs who frequently disagree with your determinations or HO decisions.

Notify your CMS RO if you find a pattern of ALJ reversals that disagree with your or CMS policy.

Make sure at least one copy of the findings from analyzing reversals is sent to the manager of the HO hearing unit. The manager will circulate a copy to all of their HOs.

Where there is no manager, send at least one copy to the HO hearing unit to be circulated among the HOs.

In those cases where the HO is located off-site, make a copy available to each HO.

Part of the purpose of the feedback loop is to give the HOs an opportunity to see why their cases were overturned, and to learn how to strengthen future decisions, by taking note of what ALJs include in writing their decisions.

If there are continual reversals of a contractor policy or CMS policy, the policy needs to be reexamined, even though the conclusion may well be that it is an appropriate policy.

12045 MANAGING WORKLOAD

Although you should generally use a first-in, first-out method for processing appeals, there may be times when prioritization of your workload will become necessary. In order to manage your workload, you should begin to backlog workloads beginning with the lowest priority listed (i.e., Priority 8) and work sequentially backwards. When it becomes necessary to begin a backlog, you must notify your RO prior to prioritizing your work in accordance with the priorities listed below.

For the purposes of this section, backlogging an appeal occurs when a contractor is unable to process and/or adjudicate an appeal in the timeframes specified in the BPRs.

Priority 1.--Finalize effectuation of all Administrative Law Judge decisions and DAB decisions and respond to requests for case files;

Priority 2.--Adjudicate all request for telephone appeals (if applicable) in a timely and effective manner;

Priority 3.--Adjudicate written reconsiderations, reviews, and fair hearings from beneficiaries or their appointed beneficiary representative with or without documentation within the time frames prescribed in the FY 2001 Budget and Performance Requirements (BPRs);

Priority 4.--Adjudicate written requests for reviews and fair hearings from providers, suppliers, or other appellants', including States or their third party agents, that are submitted with necessary documentation within the time frames prescribed in the BPRs;

Priority 5.--Adjudicate written requests for reviews and fair hearings from providers, suppliers, or other appellants, including States or their third party agents, that are submitted without necessary documentation within the time frames prescribed in the BPRs;

Priority 6.--Prepare, assemble, and forward ALJ Hearing case files that contain necessary documentation within the time frames prescribed in the BPRs;

Priority 7.--Prepare, assemble, and forward Part B ALJ Hearings case files that do not contain necessary documentation within the time frames prescribed in the BPRs; and

Priority 8.--Submit agency referrals to the Departmental Appeals Board (DAB).

Reopening and Revisions

12100. REOPENING AND REVISION OF CLAIMS DETERMINATIONS AND DECISIONS

When a determination is made on a claim for Part B services, the beneficiary (and the physician or other supplier of medical services) should be able to rely on it with respect to the coverage of the services and the amount of payment. However, there are instances in which strong equities exist, both for the party(ies) to the determination and for the Government, in favor of reopening incorrect initial, revised, or reviewed determinations, or HO decisions. The regulations do not permit unrestricted reopening of determinations and decisions. They do set specific circumstances under which a determination or decision may be reopened.

Reopen only if the new information is significant and material, or discloses an error on the face of materials. A reopening is not an appeal right. It is a discretionary action as defined in 42 CFR 405.841, which you or HOs take if good cause exists. It is an action which you take on your own volition or following a written request of the claimant when refusal to reopen would either inflate costs to the Government without a commensurate benefit to the claimant, or deprive the claimant of rightful payment. A reopening is rarely necessary for claims prior to the review since most errors are easily corrected at the review. Do not grant a reopening in the absence of additional and relevant information or a clear error. Never conduct a reopening in response to an appeal request if appeal rights are available. Your decision not to reopen is not subject to appeal.

Historically, some carriers have a variety of informal procedures under the general heading of "reopenings", "re-reviews", "informal reconsiderations", etc. Physicians and suppliers may have come to view these as appeal rights. These are not part of the appeals process. They are not a claimant's right. They are not additional levels of appeal. Do not use them to provide an appeal when a formal appeal is not available.

CMS policy is to reopen following a written request only after appeal rights are exhausted, or the time limit for requesting an appeal has expired. This ensures that reopenings will not be used instead of specified and requested appeals.

If the reason for denial is appealable to SSA rather than to you, refer the reopening request to SSA. Notify the claimant that the request is being referred to SSA for consideration. The following are appealable only to SSA:

- Beneficiary is not entitled to Part B;
- Beneficiary is not eligible for benefits;

If a claim requiring medical documentation is submitted without documentation, and the claimant is otherwise entitled and eligible, deny the claim for lack of medical necessity. If the medical information is

subsequently submitted and a reopening is explicitly or implicitly requested, treat it as a request for review unless the appeal period has expired. (Should the request relate to a review determination, treat it as a request for hearing, and if it relates to a HO decision, treat it as a request for an ALJ hearing.) Obtain a signed written request if the request is oral.

Section 12999, Exhibit 18 explains the policy on reopenings and appeal rights, and that appellant physicians/suppliers are responsible for providing the information needed to support the appeal. Exhibit 19 is a CMS policy statement on reopenings to help you respond to requests for reopenings prior to the expiration of appeal rights.

Following a fair hearing, and pending a requested ALJ hearing, you may receive information that might affect payment. Review it, but do not reopen your decision. The ALJ has jurisdiction. Count and charge the activity as ALJ case preparation on line 2 of the Administrative Budget and Cost Report.

Forward the information for incorporation into the hearing file. Review your copy of the file to ensure that the file sent to the ALJ is complete. A test is whether or not someone not involved in the ALJ review process can understand what you did, why you did it, and the basis for your decision. ALJs are not required to defer to your rationale. They may, if they understand why you decided as you did.

12100.1 Budgeting Allocation and Workload Reporting--Charge actions as follows on the Administrative Budget and Cost Report (Form CMS-1524):

Action	Line
• (Initial claims processing)	1
- Oral/written inquiries	3
- Correction of errors (revisions)	1
- Written request for review	2
- Reopening (time for appeal has passed)	1
- Self-initiated revisions	1
• (Review)	2
- Reopening (time for appeal has passed)	1
- Written request for fair hearing	2
- Oral/written inquiries	3
- Self-initiated revisions	1
• (Fair Hearing)	2
- Reopening (time for appeal has passed)	1
- Case preparation/written request for ALJ hearing	2
- Oral/written inquiries	3
- Self-initiated revisions	1

12100.2 Development of Appeals.--Physicians and suppliers are responsible for providing the information needed to adjudicate their claims. Instruct them to provide the information with the claim filing. Failing that, if they appeal your decision, they must provide relevant information.

If the claimant is the beneficiary, develop the claim. For all claimants, develop information which is in your, CMS's or SSA's files.

Include in the physician's, supplier's, or other provider's denial notice, or other communication you deem more appropriate, a list of documents needed to support the appeal, such as: physician orders, test results, consultation reports, physician certifications of medical necessity. (§12999, Exhibit 16 provides a list to modify based upon your experience.) If a physician has not been successful in obtaining necessary documentation and requests help, provide it. If for example, a hospital has failed to supply the information, contact it on the physician's behalf. Facilitate, do not initiate.

If, subsequent to the review or fair hearing, additional information is submitted, you are not required to grant a reopening. Consider a reopening only where appeal rights have expired or have been exhausted.

If a request for an ALJ hearing has been filed, regardless of whether or not time limit has expired, the ALJ has jurisdiction.

12100.3 How Issues May Arise.--A party whose right to review or fair hearing has expired may express dissatisfaction with a denial or the amount of the payment, or additional evidence may be brought to light. If dissatisfaction is expressed after the right to review or fair hearing has expired and no extension has been granted or if you or a HO thinks that a determination or decision may be erroneous and should be reopened, follow §§12100.2-12100.17. If a decision is reopened as a result of a beneficiary request and a less favorable determination is suggested, follow §12010.3.

12100.4 Summary of Conditions Under Which a Determination or Decision May Be Reopened.--Your initial, or review determination or a decision by a HO may be reopened under the following conditions: (See §12100.7 for necessary actions.)

- Within 12 months after the date of the determination or decision it may be reopened for any reason;

- After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or

- At any time, if:

  - Such initial or review determination was procured by fraud or similar fault of the beneficiary or some other person; or

  - The decision is unfavorable to the party or parties, in whole or part (for definition of an unfavorable determination, see §12100.9), but only for the purpose of correcting a clerical error or error on the face of the evidence on which the determination or decision or an unfavorable part was based.

12100.5 Determining Date of Initial or Reviewed Determination, or HO's Decision.--

A. Date of Initial Determination.--The date of the EOMB or disallowance notice prepared in accordance with §7002.

B. Date of Reviewed Determination or HO's Decision.--The date of the notice of the review determination, or the HO's decision, sent to the beneficiary or his representative.

12100.6 Who May Reopen an Initial or Reviewed Determination or HO's Decision.--You may reopen an initial or reviewed determination. A decision by a HO may be reopened only by the HO, unless he is unavailable for reasons of death, termination of employment, illness, or leave of absence. In such event, the decision may be reopened by another HO selected by you.

12100.7 Actions to Permit Reopening Within the l-Year or 4-Year Period.--To reopen a determination or decision, other than at your own initiative, it is necessary that a written request be filed by a party to the determination or decision, or by his or her authorized representative, within the applicable time limit, specified in the regulations.

The decision to conduct a sample study of a physician's or supplier's claims constitutes a reopening of all determinations in the population from which the sample is drawn, but only when such a decision is documented and is clearly intended to question the correctness of all such determinations. Send a notice to the physician or supplier as soon as possible explaining:

- The reason for the study (e.g., possible overutilization of services),
- The period to which the results of the sample study will be applied, and
- The sampling procedure, including the method used to select the sample and an explanation that the sample findings will be projected to the entire population of claims for the period in question.

Do not send a notice if the study is being performed because fraud is suspected.

A peer review recommendation questioning a previous determination or decision constitutes a basis for reopening within the 4-year period only if the recommendation is based on new and material evidence. The determination or decision will be considered reopened as of the date you or the HO accepts such a recommendation rather than as of the date of any action by the peer review group.

12100.8 Good Cause for Reopening.--"Good cause for reopening" exists where:

- New and material evidence, not readily available at the time of the determination, is furnished;

- There is an error on the face of the evidence on which such determination or decision is based; or,

- There is a clerical error in the claim file.

12100.9 Definitions.--

A. "New and Material Evidence".--Includes any evidence which was not considered when the previous determination or decision was made and which shows facts not available and that may result in a conclusion different from that reached in the determination or decision. Thus, the submittal of any additional evidence is not a basis for reopening. The information must be "new," i.e., not readily available or, known to exist at the time of the initial determination.

The evidence may justify or even require further development before a proper revised determination or decision is made. If the reopening is requested by a supplier or physician, any additional development is to be done by the claimant. If the claimant cannot complete the development, assist to the extent you can.

B. "Clerical Error".--The term, for purposes of reopening a determination or decision within the periods specified in §12100.4, includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding and card punching, computer errors, or misapplication of reasonable charge profiles or screens.

C. "Error on Face of the Evidence".--Exists if it is clear that the determination or decision was incorrect based on all evidence in file on which the determination or decision was based, or any evidence of record anywhere in your Medicare file or in the SSA or CMS files at the time such determination or decision was made. (RRB records are considered as a part of the SSA records for this purpose.)

D. Illustrations.--An error is considered to be an "error on the face of the evidence" in situations such as the following:

l. Reopening Within 4 Years Only.--

- Payment of a bill without reducing the amount payable on account of a deductible or coinsurance requirement;

- A duplicate payment;

- Payment to a person who did not bill for, and was not entitled to, the benefit; or

- Payment for a service which the evidence in file clearly shows is not covered by reason of a specific exclusion (e.g., payment for services paid for by the Federal Government or payment for items shown in the file to be covered by WC).

2. Reopening at Anytime.--

- The person for whom the services were paid was not entitled to Part B, but impersonated another who was entitled to Part B;

- The decision is unfavorable to the beneficiary or assignee, and there is an error on the face of the record on which the decision was based;

- You applied an excessive deductible or coinsurance amount based on incorrect information on file; or

- You failed to pay for services or items which the evidence in file clearly shows to be covered.

NOTE: Errors on the face of the record are not determined following a reevaluation of the information in file. The errors are obvious and easily seen once brought to your attention.

E. "Unfavorable Determination".--If the claimant is paid less than the amount claimed minus any applicable deductible or coinsurance.

12100.10 Unrestricted Reopening.--

A. Fraud or Similar Fault.--A determination or decision may be reopened at any time if it was procured by fraud or similar fault, regardless of whether criminal prosecution has been or will be instituted. The fraud or similar fault may be that of the beneficiary, provider, physician, or any other person. It includes:

- Deception by a person who knows that the deception may result in unauthorized benefits to someone;

- An act which approximates fraud, i.e., the furnishing of information which the individual knows is incorrect or incomplete, or the deliberate concealment of information, with or without a judicial finding of fraud;

- A pattern of program abuse by physicians or suppliers resulting from practices that are inconsistent with accepted sound fiscal, business, or medical practice, such as:

  - The furnishing of services in excess of the individual's needs, or of a quality that does not meet professionally recognized standards of health care; or

  - The submittal of incorrect, incomplete or misleading information that results in payment for services:

    + That were not furnished;

    + That were more expensive than those furnished;

    + That were not furnished under the conditions indicated on the bill.

  - The submittal of, or causing the submittal of, bills or requests for payment containing charges for Medicare patients that are substantially in excess of the amounts the physician or supplier customarily charges.

- An act or pattern of program abuse involving collusion between the supplier and the recipient that results in higher costs or charges to the program;

- Any act that constitutes fraud under Federal or State law.

B. A Determination that "Fraud or Similar Fault".--is present depends on the facts. For example, a claim may be reopened more than 4 years after payment was approved, if the evidence establishes a pattern of billing by a physician for weekly routine visits to patients in a nursing home for whom, under established standards of good medical practice, not more than one visit a month was medically reasonable and necessary.

12100.11 Reopening an Initial Decision.--You may reopen at your own initiative an initial determination to correct a processing error. However, except as provided in §12100.10, a determination may not be reopened at the claimant's request unless:

- Appeals have been exhausted or have expired, and

- The claimant supplies new, substantive, and material information that may cause a full or partial reversal of the determination, or

- There is a clerical error or an error on the face of the evidence on which the decision was based which caused you to make an incorrect decision.

Following denial, if the claimant expresses dissatisfaction or requests a reevaluation within the 6 month timeframe for appeal, conduct a review, not a reopening.

12100.12 Reopening a Review Determination.--You may reopen a review determination. However, except as provided in §12100.10, a determination may not be reopened at the claimant's request unless:

- Appeals have been exhausted or have expired, and

- The claimant supplies new, substantive, and material information that may cause a full or partial reversal of the determination, or

- There is a clerical error or an error on the face of the evidence on which the decision was based which caused the carrier to make an incorrect decision.

Following a review, if the claimant expresses dissatisfaction or requests a reevaluation within the 6 month timeframe for appeal, do not conduct another review. Forward the claim to the HO for a fair hearing.

You may revise a review determination if you determine, based on the review of evidence, that a full reversal would result, thereby obviating the need for the fair hearing. Revise only if an appeal has not been filed. If the claimant has requested the fair hearing, revise the claim after its return by the HO. The HO will have explained to the claimant in the dismissal letter that the claim is being returned to you for payment. (If a full reversal is not indicated, the HO will proceed with the fair hearing.

12100.13 Reopening a Fair Hearing Decision.--While a HO's decision is final and binding, the regulations provide for a reopening and revision under certain circumstances. However, a reopening can only be conducted if the criteria in §12100.11 are met. Either upon the motion of the HO or upon petition of any party to a hearing, a HO may reopen and revise his decision in accordance with 42 CFR 405.841. A decision by a HO may be reopened and revised only by that HO unless he is unavailable for reasons including death, termination of employment, illness, or leave of absence. In that event, a decision may be reopened and revised by another HO selected by you.

If the HO reopens a decision, he notifies the claimant, or his representative, in writing that a revision of the decision is proposed with respect to a specific finding. He asks the claimant or his representative if he has further documentary evidence or testimony to submit. If he revises the decision, he sends a notice of the revised decision to each party.

12100.14 Notice of Results of Reopening.--Parties with an interest in a claim receive notice of the reopening decision if it changes the original decision. Caption a revised decision as such, but the extent of actual revision depends upon the particular case. Generally, it is sufficient to refer to the date of the original decision and that part which you or the HO plans to revise. Give the reasons for the revision, including applicable law, a summary of additional evidence and rationale, and the specific finding as revised. Incorporate any additional evidence, as well as the revised decision, as part of the record.

The revised decision must convey that if the claimant is dissatisfied and the amount in controversy is $100 or more, he/she has a right to a fair hearing. However, if the amount in controversy is less than $100, there are no other appeals available, unless claims can be combined to meet the $100 threshold.

If the reopening does not result in a revision do not describe appeal rights, because the party has no remaining appeal rights.

12100.15 Exception to Sending Notice of Revision to Parties--Cases Involving Limitation on Recovery from Beneficiary.--Waive recovery of an overpayment from a beneficiary who is without fault where the determination or decision that the services were noncovered was made in the fourth calendar year after the year in which you approved the payment. (See §7115.lD) If a revised determination or decision results in a finding of overpayment for which the beneficiary would be liable (per §7102.4), but it appears that the conditions for automatic consideration of waiver are met, do not send a notice of the revision to any party. Refer the overpayment to CMS. (See §7115.1D.)

12100.16 Refusal to Reopen Is Not an "Initial Determination".--A finding that a prior determination or decision may not be reopened is not an "initial determination or decision." No right to appeal from such a finding exists. Accordingly, do not include a statement concerning the right to an appeal in any letter sent to the parties to such a determination or decision.

12100.17 Revised Determination or Decision.--A revised determination or decision is one in which:

- The end result is changed (e.g., a service previously found to be covered is now found not to be covered or the reasonable charge for the service is determined to be incorrect); or

- The end result is not changed, but a party might be disadvantaged by the revision (e.g., a request for payment on an assigned claim previously disallowed because the services were not medically necessary and therefore subject to the waiver of liability provisions, is now to be disallowed on a basis that precludes consideration of waiver of liability).

12900. GLOSSARY

Administrative Law Judge (ALJ)--

Adjudicator employed by the Social Security Administration's (SSA) Office of Hearings and Appeals (OHA) to resolve Part B claims controversies at the ALJ hearing level of appeal. (See 42 CFR §405.855.)

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 it's contractors often use this term when a reviewer or hearing officer reaches the same conclusion as that in the prior determination, even though they are not bound by the prior determination.

Agency Referral (formerly known as the Agency Protest Process)--

CMS will bring an ALJ's decision or dismissal to the attention of the DAB by asking the DAB to review the case under its own motion review authority. CMS makes an agency referrals where (1) the ALJ's decision/dismissal does not conform to the applicable law and regulations which are binding upon ALJ's, (2) where there has been an abuse of discretion by the ALJ, (3) where the ALJ's decision/dismissal is not supported by substantial evidence, or (4) where there is a broad policy or procedural issue that may affect the general public interest.

Amount in Controversy--

The dollar amount required to be in dispute to establish the right to a particular level of appeal. The amount in controversy requirements are established by Congress.

Appellant--

The term used to designate the party (i.e., the beneficiary, the physician or other supplier, or other person showing an interest in the claim determination) that has filed an appeal, or on whose behalf an appeal has been filed. Although a representative may actually file the appeal request, they are not the appellant. The adjudicator determines if a particular appellant is a proper party.

Claimant--

A person or entity that submits a claim for payment or on whose behalf a claim is submitted, commonly used by the Social Security Administration. "Claimant" is purposely omitted from Medicare appeals terminology because it is not specific enough to describe a person or entity's appeals status. The term "appellant" is used by Medicare to identify the individual or entity that is appealing a claim.

De Novo--

Latin phrase meaning "anew" or "afresh", used to denote the manner in which claims are adjudicated through the ALJ level of appeal. 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.

Medicare regulations use the term "determination" in the following appeals contexts: 1) initial determination, 2) review determination, 3) limitation on liability determination, and, 4) physician or supplier refund determination. A determination that is reopened and thereafter revised is called a "revised determination."

Medicare regulations use the term "decision" in the following appeals contexts: 1) Hearing Officer hearing decision, 2) ALJ Hearing decision, 3) Departmental Appeals Board decision, and, 4) Administrator decision. A decision that is reopened and thereafter revised is called a "revised decision."

Departmental Appeals Board (DAB) Review--

A party dissatisfied with an ALJ's decision, or with an ALJ's dismissal of his/her hearing request, may request DAB review within 60 days after receipt of the notice of the ALJ's hearing decision or dismissal. The DAB may deny or dismiss the request for review, or it may grant the request and either issue a decision or dismissal or remand the case to an ALJ. The DAB may take any action an ALJ could have taken. This could include, for example, vacating an ALJ decision and issuing a dismissal with respect to the request for ALJ hearing.

The DAB may also initiate own motion review of the ALJ's hearing decision or dismissal within 60 days after the date of the hearing decision or dismissal. An agency referral by CMS to the DAB of an ALJ decision or dismissal may result in the own motion review of the decision or dismissal by the DAB.

The DAB may also reopen an ALJ's decision or dismissal for good cause.

Dismissal--

A request for appeal may be dismissed for any number of reasons, including: abandonment of the appeal by the appellant; a request is made by the appellant to withdraw the appeal; an appellant is determined to not be a proper party; the amount in controversy requirements have not been met; the appellant has died and no one else is prejudiced by the claims determination.

A dismissal of a request for review may not be appealed. A HO dismissal may not be appealed, however for good cause shown, a Hearing Officer may vacate (i.e., set aside or rescind) his/her order of dismissal within 6 months of the date of the dismissal.

An ALJ's dismissal may be vacated by the ALJ or the Departmental Appeals Board for good cause within 60 days after the date of receipt of the dismissal notice.

Expedited Appeals Process--

A process available to a party whereby he/she can request court review in place of ALJ hearing or Departmental Appeals Board review. The request must both allege that there are no material issues of fact in dispute; and, it must assert that the only factor precluding a decision favorable to the party is that a statutory provision is unconstitutional, or that a regulation, national coverage decision under §1862(a)(1) of the Act, or CMS ruling is invalid.

Limitation on Liability Determination--

Under §1879 of the Act, when items or services are furnished by a physician or other supplier under assignment, but are excluded from coverage because they are one of the denials listed under §1862(a)(1) or (a)(9) or §1879(g) of the Act, the adjudicator of the claim must then determine whether the beneficiary and/or the physician or other supplier knew or could reasonably have been expected to know that the items or services furnished would be excluded from Medicare coverage. (This is the limitation on liability determination.) If the adjudicator finds that both the beneficiary and the physician or other supplier did not know, and could not reasonably have been expected to know, that the services would be excluded from coverage, Medicare will pay for the services. If it is determined that either the beneficiary, or the physician or other supplier, or both, knew or could reasonably have been expected to know that the items or services would not be covered by Medicare, Medicare will not pay for the services and liability for payment will shift to the beneficiary (if it is determined that the beneficiary knew, or could reasonably have been expected to know). If it is determined that the beneficiary did not know, and could not reasonably have been expected to know, then the physician or other supplier doesn't receive payment for the items or services at issue.

Both the underlying coverage determination and the limitation on liability determination may be challenged.

Office of Hearings and Appeals (OHA)--

The organizational unit within SSA under which jurisdiction for SSA's ALJs rests. Contractors forward requests for Part B ALJ hearing, along with the case file, to the SSA/OHA/Division of Medicare - Part B (formerly known as the "Part B Development Center"), for processing.

Party--

A person and/or entity normally understood to have standing in the initial and appellate proceedings. Parties to an initial claim determination receive all applicable notices relating to the initial and appellate proceedings.

Beneficiaries are almost always considered parties to a Medicare determination as they are entitled to appeal any determination related to their claim(s).

Physicians or other suppliers accepting assignment are parties and may appeal any claim(s) for which they have accepted assignment.

A physician not taking assignment on a claim but who is responsible for making a refund to the beneficiary under §1842(l)(1) of the Act has party status with respect to the claim at issue.

A nonparticipating supplier responsible for making a refund to the beneficiary under §1834(a)(18) of the Act has party status with respect to the claim at issue.

A supplier of medical equipment and supplies furnishing items or services to a beneficiary not on an assigned basis and responsible for making a refund to the beneficiary under §1834(j)(4) of the Act has party status with respect to the claim at issue.

Physician or Other Supplier--

As used in this section, it includes a physician or other practitioner, supplier, or an entity other than an institutional provider, that furnishes health care services under Medicare.

NOTE: The term “practitioner” is generally subsumed under the term “supplier” as that term is defined.

Remand--

"To send back"--sending a case back to a previous appeal level, for the purpose of having some action taken there.

Reversal--

Although appeals through the ALJ hearing level 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.

If you or the HO determines the case partially in favor of the appellant (i.e., he/she issues a determination/decision more favorable to the appellant than at the last level of adjudication, but that is still less than fully favorable), Medicare calls this a "partially favorable determination/decision." Medicare does not use the term "partial denial."

Revised Determination or Decision--

An initial or review determination or Hearing Officer decision that is reopened and which results in a revised determination or decision being issued. A revised determination or decision is considered a separate and distinct determination or decision and may be appealed.

A postpayment review of an initial determination that results in an overpayment determination constitutes a revised initial determination. The first level of appeal following an overpayment determination under Part B is the HO hearing if at least $100 remains in controversy. If less than $100 remains in controversy, a review would be available.

12999. LIST OF EXHIBITS

Exhibit 1 Appointment of Representative - Form CMS-1696-U4
(Available in hardcopy (paper) only)

Exhibit 2 Request for Review of Part B Medicare Claim - Form CMS-1964
(Available in hardcopy (paper) only)

Exhibit 3 Request for Hearing - Part B Medicare Claim - Form CMS-1965
(Available in hardcopy (paper) only)

Exhibit 4 Request for Part B Medicare Hearing by an ALJ - Form CMS-5011B
(Available in hardcopy (paper) only)

Exhibit 16 Model Letter to Supplier or Independent Practitioner

Exhibit 17 Recommended Responses to Requests for Reopenings

Exhibit 18 Special Notice to Physicians Suppliers and Other Independent Practitioners

Exhibit 19 Reopenings Policy

Exhibit 1 - Appointment of Representative - Form CMS-1696-U4

Exhibit 2 - Request for Review of Part B Medicare Claim - Form CMS-1964

Exhibit 3 - Request for Hearing - Part B Medicare Claim - Form CMS-1965

Exhibit 4 - Request for Part B Medicare Hearing by an ALJ - Form CMS-5011B

THE NEXT PAGE IS 12-126--EXHIBIT 16.

Exhibit 16 - Model Letter to Supplier or Independent Practitioner

If you decide to appeal this decision, we ask that you submit documentation to support your appeal. Forwarding this information with your appeal will facilitate processing and payment, if appropriate.

Only you can decide on the documentation that best supports your claim. Nevertheless, you may want to consider the following:

- X-Ray reports
- Test results
- Medical history
- Documentation of severity or acute onset
- Consultation reports
- Billing forms
- Referrals
- Plan of treatment
- Nurse's notes
- Copies of communications between physician and/or beneficiary, hospital, carrier, laboratory, etc.

If you are unsuccessful in obtaining information, let us know. We will assist to the extent we can.