



## **THE TIMES THEY ARE A CHANGIN': NEW TIME FRAMES AND PROCESSES FOR MEDICARE APPEALS**

### **Introduction**

In 2000, Congress enacted legislation allegedly designed to streamline and make uniform the appeals systems for claims arising under Parts A and B of Medicare. Although the new provisions were supposed to go into effect in 2002, the Centers for Medicare & Medicaid Services (CMS) only effectuated changes concerning the time for filing appeals from initial decisions and the reduced amount in controversy for hearings on Part B claims. Congress made additional changes to the appeals process in 2003, including authorizing the transfer of administrative law judges (ALJs) from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS), and negating some of the earlier time savings by extending the time in which contractors must complete their decisions.

In the federal register on Tuesday, March 8, CMS issued interim final regulations to implement the changes to the appeals process for Medicare Part A and Part B claims, and to implement changes to ALJ hearing process for all Medicare claims, including managed care claims and future prescription drug claims. 70 Fed. Reg. 11420 (March 8, 2006). Because of the extensive nature of the changes, the Center for Medicare Advocacy will issue a series of *Weekly Alerts* to explain how the new processes will operate. This week's *Alert* will address changes to the Part A and Part B process. Next week we will address changes to the ALJ hearing process. The third *Alert* will address changes to the Medicare Part C (Medicare Advantage) appeals process that result from final rules issued by CMS in January. The final *Alert* will address practice issues concerning representation of beneficiaries in Medicare appeals.

### **Initial Determinations and Redeterminations**

As in the past, the claims process begins when the appropriate Medicare contractor (currently called a fiscal intermediary, carrier, or durable medical equipment regional carrier) issues an initial determination of a claim submitted by the medical supplier or provider or, occasionally, by the beneficiary. The regulations make clear that the initial determination, which will still be issued as the Medicare Summary Notice (MSN), goes only to the beneficiary, even when the contractor is aware that the beneficiary has an appointed representative. Someone who wants to appeal from the initial determination must submit a written, signed request for a redetermination within 120 days of the initial determination; the regulations assume the notice is received 5 days after the date of the notice. **Requests for redeterminations must be filed with the office indicated on the MSN; beneficiaries can no longer file requests with Social Security offices.**

The regulations also, for the first time, allow providers and suppliers to request appeal of a denial of an initial determination, raising the possibility that both the beneficiary and the provider or supplier will initiate the appeals process. In such a case the contractor must consolidate the appeals. The contractor has 60 days from receipt of the redetermination request to issue a decision. If more than one party files a request, the time period runs from the date the last request is received. For example, if a beneficiary files a redetermination request on day 1, but the provider files on day 50, the 60-day time period for the contractor to act starts on day 50.

Unlike the MSN, the notice of the redetermination will be sent to a beneficiary's appointed representative. The notice will explain the facts, policies and law relied upon in making the redetermination decision; the right to request a reconsideration and the process for doing so; and a statement of specific missing documents that must be submitted. **The notice will state that providers and suppliers, but not beneficiaries (unless they are represented by a provider or supplier), must submit all of their evidence at the next level of review in order for the evidence to be considered at any further stage of the appeals process.** It is unclear whether CMS will require contractors to send different notices to beneficiaries and suppliers/providers, or whether CMS will include in the redetermination notice a statement that evidentiary limitations do not apply to beneficiaries. In addition, contractors will not be required to send redetermination notices to multiple beneficiaries in overpayment cases brought by providers or suppliers if the beneficiary allegedly has no liability for the claim. It is unclear how the contractor will determine in such cases whether the beneficiary has already paid for the service in question.

The regulations create a new **reopening** process to be used instead of the redetermination process to correct minor errors or omissions in initial determinations. This process responds to a new section of the Medicare law that allows providers and suppliers to correct minor mistakes without going through the appeals process. Reopenings can also be used at subsequent levels of review. Questions remain concerning the relationship of the new reopening process and the process for deciding remanded cases, as well as the ability of a contractor to reopen a decision in favor of the beneficiary.

## **Reconsiderations**

The 2000 law created a third level of review, the **reconsideration**, which replaces the Part B Fair Hearing and adds another review step for Part A claims before the ALJ level of review. Reconsiderations will be conducted by a new group of Medicare contractors called **Qualified Independent Contractors (QICs)**. Beneficiaries and other parties to the redetermination have 180 days to request a reconsideration by filing a request at the location indicated on the redetermination notice. Again, reconsiderations filed by beneficiaries and the provider/supplier will be consolidated, and the time for issuing a decision runs from receipt of the last-filed appeal.

Because of the complexity and cost of implementing a new level of review, CMS has decided to phase in the reconsideration process. Starting May 1, 2005, appeals of redeterminations by the fiscal intermediaries, including hospital, skilled nursing facility, home health, outpatient hospital services, and hospice claims, will go through the QIC reconsideration. Appeals of Part B redeterminations involving claims for doctor's services and durable medical equipment will continue to go to a fair hearing for the rest of 2005. Reconsiderations of Part B determinations

issued on or after January 2006 will be conducted by the QICs. Maximus, the organization which reviews Part C appeals and appeals involving Medicare discount drug cards, has announced that it will serve as a QIC to conduct reconsiderations starting in May.

The reconsideration level of review is a paper review; CMS states clearly in the preamble to the final regulations that QICs will not be conducting hearings. However, the QIC is supposed to solicit the view of the beneficiary. As noted above, providers and suppliers are required to submit all of the evidence they want considered in the claim to the QIC. Evidence not submitted may be excluded at subsequent levels of review.

The QIC is supposed to complete its reconsideration within 60 days of the reconsideration request. Again, the time frame runs from the last request filed if more than one party seeks reconsideration; the QIC must so notify a party who filed an earlier request. The regulations do not indicate how QICs are supposed to document receipt or how beneficiaries are to know when the 60-day period ends. Although the statute allows a party to the reconsideration to ask for an extension of not more than 14 days for the QIC to conclude the reconsideration, the regulations add 14 days to the reconsideration time frame each time that additional evidence is submitted.

If a QIC does not issue a timely decision, the statute allows a party to request that the appeal be escalated to the next level of review, the ALJ level. The regulations give the QIC 5 days to either issue a decision or acknowledge the escalation request and send it to the ALJ level of review. The regulations indicate that an appeal escalated to the ALJ level will be completed within 180 days of receipt, rather than the statutorily mandated 90 days for ALJ decisions.

*The Center will continue its series of Weekly Alerts to describe the new Medicare appeals process over the next few weeks. If you have questions, please contact Brad Plebani ([bplebani@medicareadvocacy.org](mailto:bplebani@medicareadvocacy.org)) in the Center's Connecticut office at 860-456-7790, or Vicki Gottlich ([vgottlich@medicareadvocacy.org](mailto:vgottlich@medicareadvocacy.org)), or Alfred Chiplin ([achiplin@medicareadvocacy.org](mailto:achiplin@medicareadvocacy.org)) in the Center's D.C. office, at 202-216-0028.*