CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1965	**Date: May 7, 2010**
	Change Request 6894

SUBJECT: Appeals Revisions - AIC Requirements

I. SUMMARY OF CHANGES: This change request updates information in accordance with the 42 Code of Federal Regulations (CFR), Parts 401 and 405 Medicare Program Changes to the Medicare Claims Appeals Procedures; Final Rule on requirements for the amount that must remain in controversy to file a level 3 (administrative law judge hearing) and level 5 (federal district court) appeal. CMS is adding information to the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy and Aggregation of Claims to meet amount in controversy sections and updating information related to the current year threshold amounts for all relevant sections.

EFFECTIVE DATE: August 9, 2010
IMPLEMENTATION DATE: August 9, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/220/Steps in the Appeals Process: Overview
R	29/250/Amount in Controversy Requirements
R	29/250.1/Amount in Controversy General Requirements
R	29/250.2/Principles for Determining Amount in Controversy
R	29/250.3/Aggregation of Claims to Meet the Amount in Controversy
R	29/330.1/Right to an ALJ Hearing
R	29/345.1/Requests for U.S. District Court Review by a Party

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1965	Date: May 7, 2010	Change Request: 6894

SUBJECT: Appeals Revisions - AIC Requirements

EFFECTIVE DATE: August 9, 2010
IMPLEMENTATION DATE: August 9, 2010

I. GENERAL INFORMATION

A. Background: This change request updates information in accordance with the 42 Code of Federal Regulations (CFR), Parts 401 and 405 Medicare Program Changes to the Medicare Claims Appeals Procedures; Final Rule on requirements for the amount that must remain in controversy to file a level 3 (administrative law judge hearing) and level 5 (Federal District Court) appeal. CMS is adding information to the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy and Aggregation of Claims to meet amount in controversy sections and updating information related to the current year threshold amounts for all relevant sections.

B. Policy: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 1869 (c) of the Social Security Act (the Act), as amended by BIPA, required changes to the 42 Code of Federal Regulations regarding the appeals process. BIPA established threshold amounts for ALJ hearing requests and judicial review requests. MMA required the AIC threshold amounts to be adjusted annually.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6894.1	Contractors shall note changes made to the manual sections and shall note the updates made to the amount in controversy thresholds.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
6894.2	A provider education article related to this instruction will be available at http://www.cms.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Liz Hosna (Katherine.Hosna@cms.hhs.gov), Maria Ramirez (Maria.Ramirex@cms.hhs.gov)

Post-Implementation Contact(s): Liz Hosna (Katherine.Hosna@cms.hhs.gov), Maria Ramirez (Maria.Ramirex@cms.hhs.gov)

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs),*** **include the following statement:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

220 - Steps in the Appeals Process: Overview

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

Regulations at 42 CFR 405.940- 405.942 provide that a party to a redetermination that is dissatisfied with an initial determination may request that the contractor make a redetermination. The request for redetermination must be filed within 120 days after the date of receipt of the notice of the initial determination (The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary). Contractors cannot accept an appeal for which no initial determination has been made. The parties specified in §210 who are dissatisfied with a determination on their Part A or B claim have appeal rights.

The 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.

The appellant must begin the appeal at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps the appellant must take before appealing to the next level. If the appellant meets the procedural steps at a specific level, the appellant *(and all other parties to the appeal decision)* is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination or decision to the next higher level, until appeal rights are exhausted. Although there are five distinct levels in the Medicare appeals process, the *redetermination,* level 1, is the only level in the appeals process that the contractor performs.

When an appellant requests a reconsideration with a QIC (level 2), the contractor must prepare and forward the case file to the QIC. Further, the contractor may have effectuation responsibilities for decisions made by the QIC. The contractor, however, does not have responsibility for reviewing the QIC's decision for accuracy. When an appellant requests an Administrative Law Judge (ALJ) hearing (level 3), the QIC must prepare and forward the case file to the HHS Office of Medicare Hearings and Appeals (OMHA). Further, the contractor may have effectuation responsibilities for decisions made at the ALJ, Departmental Appeals Board (DAB)/Appeals Council, and Federal Court levels.

In the chart below, levels 1 – 5 are part of the Administrative Appeals Process. If an appellant has completed all the first 4 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 Fee-for-Service Appeals Process

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination	120 days from date of receipt of the notice initial determination	None

2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	At least $100 remains in controversy.* For requests filed on or after January 1, *2010*, at least $*130* remains in controversy.
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of the Appeals Council decision or declination of review by DAB	At least $*1,000* remains in controversy.* For requests filed on or after January 1, *2010,* at least $*1,260* remains in controversy.

250 - Amount in Controversy Requirements

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

This section is informational only since the amount in controversy requirements only apply to the ALJ and Federal court levels.

Section 1869 (b)(1)(E) of the Act established amount in controversy threshold amounts for ALJ hearing requests and judicial review at $100 and $1,000, respectively. As amended by section 940 of the MMA, this amount will be adjusted annually. In order to continue an appeal following the QIC reconsideration level, a party must have an amount remaining in controversy that meets the threshold requirements.

250.1 - Amount in Controversy General Requirements

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

Each calendar year (beginning in 2005), the dollar threshold for the amount in controversy requirement for ALJ hearing requests or judicial review will be recalculated to reflect the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10. Changes to the amount in controversy threshold amounts are published annually in the Federal Register as per 42 CFR 405.1006(b).

250.2 - Principles for Determining Amount in Controversy

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

As part of the requirements for a hearing before an ALJ, a party to a proceeding must meet the amount in controversy provisions at 42 CFR 405.1006, including the threshold amount, as adjusted, in accordance with 42 CFR 405.1006(b).

The amount remaining in controversy is computed as the actual amount charged the individual for the items and services in question, reduced by –

(a) any Medicare payments already made or awarded for the items or services; and

(b) any deductible and coinsurance amounts applicable in the particular case.

In such cases where payment is made for items or services under section 1879 of the Act or under 42 CFR 411.400 or the liability of the beneficiary is limited under 42 CFR 411.402, the amount in controversy is computed as the amount that the beneficiary would have been charged for the items or services in question if those expenses were not paid under 42 CFR 411.400 or that the liability was not limited under 42 CFR 411.402, reduced by any deductible and coinsurance amounts applicable in the particular case.

After processing the reconsideration, the QIC shall send written notification to all parties. This notice shall include any information concerning the parties' rights to an ALJ hearing, including the applicable amount in controversy requirements and aggregation provisions.

250.3 - Aggregation of Claims to Meet the Amount in Controversy

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

A party appealing QIC reconsideration to the ALJ level and does not meet the amount in controversy threshold requirements may, under certain circumstances, aggregate claims to meet the requirements set forth in 42 CFR 405.1006. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy requirements for an ALJ hearing if –

(a) the claims were previously reconsidered by a QIC;

(b) the request for ALJ hearing lists all of the claims to be aggregated and is filed within 60 days after receipt of all the reconsiderations being appealed; and

(c) the ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the amount in controversy requirements.

In cases where claims are escalated from the QIC level to the ALJ level (if parties have met all other requirements), aggregating claims may proceed under certain circumstances. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy for an ALJ hearing if –

(a) the claims were pending before the QIC in conjunction with the same request for reconsideration;

(b) the appellant(s) requests aggregation of the claims to the ALJ level in the same request for escalation; and

(c) the ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the amount in controversy requirements.

When the appellant(s) seeks to aggregate claims in a request for an ALJ hearing, the appellant(s) must-

(a) specify all of the claims the appellant(s) seeks to aggregate; and

(b) state why the appellant(s) believes that the claims involve issues of law and fact or delivery of similar or related services.

330.1 - Right to an ALJ Hearing

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

There are three situations where a party can request a hearing before an ALJ: (1) A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration and the amount in controversy requirement is met*; (2) A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the QIC's decision-making timeframe has a right to a hearing before an ALJ if the party files a written request with the QIC to escalate the appeal to the ALJ level after the adjudication period expires and the QIC does not issue a final action within 5 days of receiving the request for escalation. A party wishing to escalate an appeal must also meet the amount in controversy requirement*; and (3) A party to a QIC's dismissal of a request for reconsideration has a right to have the dismissal reviewed by an ALJ if the party meets the amount in controversy requirement*.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, *2010* is $120. The amount remaining in controversy requirement for requests made on or after January 1, *2010* is $*130*.

* For requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement is increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10. The amount will be computed annually and CMS will notify the Medicare contractors of the new amount.

345.1 - Requests for U.S. District Court Review by a Party

(Rev.1965, Issued: 05-07-10, Effective: 08-09-10, Implementation: 08-09-10)

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S. District Court. The amount remaining in controversy for requests made *before* January 1, *2010* is $*1,220*. The amount remaining in controversy for requests made on or after January 1, *2010* is $*1,260*.
If a contractor receives, 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, the contractor shall send the original to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The contractor retains a copy and notifies its RO immediately.