Program Memorandum Intermediaries/Carriers

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

Transmittal AB-03-143 **Date: SEPTEMBER 26, 2003**

This Program Memorandum re-issues Program Memorandum AB-02-111, Change Request 2251, dated July 31, 2002. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 2251

SUBJECT: Implementation of Certain Initial Determination and Appeal Provisions Within §521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000

This Program Memorandum (PM) provides guidance to Medicare carriers and fiscal intermediaries (FIs) on the partial implementation of §521 of BIPA by October 1, 2002. Section 1869 of the Social Security Act (the Act), as amended by §521 of BIPA, substantially revises the Medicare claim appeals process. This PM also instructs standard systems maintainers to make the necessary system changes by January 1, 2003, so that the date by which an appeal must be filed with a contractor will be automatically calculated and listed on the Medicare Summary Notice (MSN). Systems maintainers should also make the necessary changes to ensure that the standard appeals information contained on the back of the MSN reflects the new filing timeframes for appeals of initial determinations. CMS will make the necessary changes to the paper and electronic remittance advice (RA), so that it too reflects the new filing timeframes for appeals of initial determinations.

This PM requires all contractors to use the new filing deadlines established by BIPA and apply the timeframes to requests for Part A reconsiderations and Part B reviews. It also instructs contractors to follow the revised amount in controversy (AIC) requirement for Part B Administrative Law Judge (ALJ) hearings. You must ensure that all sections of this PM are implemented fully by the applicable implementation date.

You should post the new filing timeframes and AIC requirement on your Web sites and publish corresponding information in your bulletins or newsletters in the next hardcopy release.

I. New Time Limits for Filing a Request for Appeal

Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations.

A. Changes to the MSN and RA

The MSN specifies the date by which a beneficiary must file an appeal of a denied claim. Although the RA codes do not identify a particular filing date for provider or supplier appeals, the codes do identify the applicable Part A and Part B filing timeframes.

1. Remittance Advice (RA)

The changes to the RA remark codes in this section (I.A.) of the PM will be included in the update to be posted at http://www.wpc-edi.com/hipaa by July 31, 2002. Therefore, physicians, suppliers and other providers will have the opportunity to view these changes prior to the October 1, 2002, implementation date. Instructions on how carriers and FIs should process beneficiary requests for appeal appear in section I.B. of this PM.

The following RA remark codes have been updated to reflect the changes in the filing deadlines: M25, M26, M27, MA01, and MAO2. The changes to the messages are identified in the chart below in bold typeface.

Remittance Advice Remark Code	Message
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim **either within 6 months of the date of this notice, if this notice is dated September 30, 2002 or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002 or later.** If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or • If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later.** However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later)**. You may make the request through any Social Security office or through this office.
MA01	(Initial Part B determination, Medicare carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**, unless you have a good reason for being late. (Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.) (Note: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)
MA02	(Initial Medicare Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration **within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**. Decisions made by a QIO must be appealed to that QIO **within 60 days**. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.)

These five codes will be revised again during the Web posting update scheduled for the last week of October 2002. At that time, the references to the Part A 60-day filing timeframe and Part B 6-month filing timeframe will be removed.

2. Medicare Summary Notice (MSN)

All contractors must make the standard systems changes identified below to the MSN by January 1, 2003. All other technical specifications will remain the same.

In the Appeals section of the MSN, continue printing only Part B appeals language, if only Part B claims information is on the MSN, and only Part A appeals language, if only Part A claims information is on the MSN. However, if the MSN includes both Part A and Part B claims information, replace the language currently used in the Appeals section with the following language:

> **Appeals Information – Part A (Inpatient) and Part B (Outpatient)**
>
> **If you disagree with any claims decision on either PART A or PART B of this notice**, you can request an appeal by (insert appeal date; the date format remains month, day, and year).

The Spanish translation for those contractors issuing MSNs in Spanish is:

> Si usted no está de acuerdo con cualquier decisión tomada en esta notificación ya sea de la Parte A o la Parte B, usted puede solicitar una apelación en o antes de (insert appeal date). Siga las instrucciones indicadas abajo:

Additionally, the appeal timeframe for both Part A and B appeals is now 120 days from the date shown on the front of this notice. Again, the date format remains month, day, and year.

The rest of the appeals instruction language, beginning with "Follow the instructions below", is not being changed.
On the back of the Part A MSN, delete the second and third sentence in the **YOUR RIGHT TO APPEAL** paragraph, and insert the following sentence:

> For Part A and Part B decisions, you must file an appeal within 120 days of the date of this notice.

The Spanish translation for contractors issuing Spanish MSNs is:

> Para decisiones de la Parte A y la Parte B, debe someter una apelación dentro de 120 días de la fecha de esta notificación.

On the back of the Part B MSN, in the second sentence of the **YOUR RIGHT TO APPEAL** paragraph, replace "6 months" with "120 days."

For those contractors issuing MSNs in Spanish, replace "6 meses" with "120 días."

B. Interim Process for Managing Beneficiary Appeal Requests

Since it will not be possible to make the MSN changes described in the previous section until January 1, 2003, you must use the following interim process for managing beneficiary appeal requests:

- Allow beneficiaries 60 days to file Part A appeal requests and 6 months to file Part B appeal requests if their initial determination is dated September 30, 2002, or earlier.
- Allow beneficiaries 120 days to file Part A appeal requests and 6 months to file Part B appeal requests if their initial determination is dated between October 1, 2002, and December 31, 2002.

- Allow beneficiaries 120 days to file Part A or Part B appeal requests if their initial determination is dated January 1, 2003, or later.

C. Reopening, Computation of Filing Timeframes, and Good Cause

If you reopen an initial determination, use the revised initial determination date to determine the applicable filing deadlines. Carriers and FIs should continue to apply the current provisions governing the computation of the filing time limits and the current provisions governing whether filing time limits may be extended for good cause.

II. Reduction of the AIC Required to Request a Part B ALJ Hearing

Beneficiaries, physicians, and suppliers wishing to file appeals must satisfy the AIC requirement in order to obtain a Part B ALJ hearing. Like the AIC requirement for Part A ALJ hearings, the AIC requirement for Part B ALJ requests will be $100, for initial determinations made on or after October 1, 2002. Only an ALJ has the authority to dismiss a request for an ALJ hearing based on the AIC requirement. Therefore, you should continue forwarding all such requests for proper adjudication. Part B hearing officer hearing decision letters must be modified to reflect the new AIC requirement, if the initial determination for the claim in question was made on or after October 1, 2002.

The *effective date* for this PM is October 1, 2002.

The *implementation date* for the non-systems changes in this PM is October 1, 2002.

The *implementation date* for the systems changes in this PM is January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2004.

If you have any questions, contact Jen Collins (410) 786-1404, Jennifer Eichhorn (410) 786-9531, or Arrah Tabe (410) 786-7129.