



Medicare Physician Services Version

KEY CONCEPTS OUTLINE

Module 14: When the Medicare Payment is Not What You Expect: Audits and Appeals

I. Medicare Audit Programs

A. Comprehensive Error Rate Testing (or CERT)

1. Overview

- a. CERT is a Medicare audit program designed to determine national, contractor specific, and service-specific paid claim error rates. <Medicare Program Integrity Manual, Chapter 12 § 12.3>

2. CERT Administration

- a. There are two separate CERT contractors:

- (i) The CERT Review Contractor

- (a) The CERT Review Contractor is responsible for reviewing all the records and comparing what was billed with what was documented to make a claim-by-claim decision if the claim was properly paid or not. <CERT Provider Website, "About Program" page>

- (1) The current CERT Review Contractor is Ais Empower AI, Inc. located in Richmond, VA

- (ii) The CERT Statistical Contractor

- (a) The CERT Statistical Contractor is responsible for the big picture analyses and may select further claims for review. <Medicare Program Integrity Manual, Chapter 12 § 12.3.2; CERT Provider Website, "About Program" page>

(1) The current CERT Statistical Contractor is The Lewin Group located in Falls Church, VA. <CERT Provider Website, "About Program" page>

3. The Scope of the CERT Claims Review

a. Claims Selection Process

(i) A random sample of claims is selected from each claims processing Contractor for inclusion in the CERT review. <Medicare Program Integrity Manual, Chapter 12 § 12.3.2>

b. Medicare Guidelines Applied to CERT Reviews

(i) In General

(a) CMS requires the CERT Review Contractor to apply all national and local coverage, coding, and billing guidelines when performing CERT reviews. <Medicare Program Integrity Manual, Chapter 12 § 12.3.3.2>

4. Identified Overpayments and Underpayments

a. If a CERT review identifies a claim that was either overpaid or underpaid, the claim is referred back to the Contractor for collection of the amount overpaid or payment of the underpaid amount. <Medicare Program Integrity Manual, Chapter 12 § 12.3.4>

5. CERT Appeals

a. CERT decisions are appealable through the normal Medicare appeals process (as discussed below). <Medicare Program Integrity Manual, Chapter 12 § 12.3.5>

6. CERT Statistics

a. The FY 2023 Medicare fee-for-service program projected improper payment rate is 7.38%, representing \$31.23 billion in improper payments, compared to the FY 2022 estimated improper payment rate of 6.46% representing \$31.46 billion in improper payments. <CMS web site page; Research-Statistics-Data.asp>

b. Separate improper payment rates are calculated for Part A and Part B.

c. Part B claims for professional services represent an improper payment rate of 8.86 % which equates to \$17.13 billion in the yearly reporting period (July 1, 2021– June 30, 2022).

d. From the 2023 CERT report, the breakdown of improper payments made by all MACs were as follows. <Medicare Fee-For-Service 2023 Improper Payments Report>

- (a) No documentation – 3.7% of total
- (b) Insufficient documentation – 62.8% of total
- (c) Medical necessity errors – 15.0% of total
- (d) Incorrect coding – 11.6% of total
- (e) Other – 6.9% of total

B. Medicare Administrative Contractor – Target Probe and Educate

1. Newest initiative: Target Probe and Educate (TPE)

- a. CMS has made the decision to adopt TPE performed at the MAC level based on favorable provider response to previous Probe and Educate (P&E) pilot programs
- b. MAC specific based on data analytics

2. Effects providers and suppliers who have high denial rates or unusual billing practices

- a. Those submitting compliant claims will NOT be included in TPE

3. TPE's purpose is to increase accuracy in specific areas through the identification of claim submission errors, and to assist physicians with correction and education.
<CMS Transmittal R1919OTN >

4. Notification:

- a. Providers will be notified via letter of inclusion
- b. May consist of three rounds of a prepayment probe review with education
 - (i) Review of 20–40 claims per “round”
 - (ii) At the end of each round, providers/suppliers will be sent a letter detailing the results of the reviews
 - (a) If claims errors are discovered, then:

1. One-on-one education sessions will be provided
 - (b) Education will also be provided throughout the TPE review process regarding easily resolved errors
 - c. Discontinuation of review may occur at any time if appropriate improvement is achieved during the review process
 - d. TPE does not amend or change the appeals process

C. The Recovery Audit Program

1. Recovery Audit Program Description

- a. As discussed in the first module, the Recovery Audit program is a congressionally mandated program resulting from a three-year Medicare demonstration program under which private companies called "recovery auditors" are paid on a contingency basis to identify Medicare underpayments and overpayments. <Medicare Financial Management Manual, Chapter 4 § 100.1 and MLN Matters Article SE0617>

2. Recovery Audit Program Appeals

- a. Overpayment determinations initiated through the Recovery Auditors are appealable through the normal Medicare appeals process (as discussed below). <Medicare Financial Management Manual, Chapter 4 §§ 100.7>

II. Medicare Appeals

A. The Initial Determination

1. The Contractor must process each clean claim submitted and make an "initial determination" on the claim within 30 days. <42 CFR §§ 405.904(a)(2), 405.922; Medicare Claims Processing Manual, Chapter 1 § 80.2.1.1>
 - a. A "clean claim" is one that can be processed by the Contractor without any investigation or development. <Medicare Claims Processing Manual, Chapter 1 § 80.2>
2. While all clean claims must be processed within 30 days, CMS has established a claims payment floor whereby claim payment must be held before payment is released. The claim payment floor is dependent upon if the claim was an electronic or a paper claim. <Medicare Claims Processing Manual, Chapter 1 § 80.2.1.2>

- a. The claim payment floor for an electronic claim is 13 days.
- b. The claim payment floor for a paper claim is 26 days.

B. Reopening of a Claim Determination

1. Separate and Distinct from the Appeals Process

- a. The request for a telephone reopening of a claim is conducted at Contractor discretion and may result in changing of a claim determination. <Medicare Claims Processing Manual, Chapter 34 § 10>
- b. Requesting a reopening does not have an impact on initiating a first level of appeal (redetermination) within the required timeframe. A Contractor's decision not to reopen a claim is not appealable. <Medicare Claims Processing Manual, Chapter 34 § 10.2>
 - (i) If reopening a claim results in a revised determination, then new appeal rights will be offered on the revised determination. <Medicare Claims Processing Manual, Chapter 34 § 10>

2. Issues That Can Be Reopened

- a. MACs are required to offer a telephone reopening process to correct minor clerical errors or omissions. <Medicare Claims Processing Manual, Chapter 34 § 10.4>
- b. CMS defines clerical errors on the part of the Contractor or the provider to include:
 - (i) Mathematical or computational mistakes;
 - (ii) Transposed procedure or diagnostic codes;
 - (iii) Inaccurate data entry;
 - (iv) Misapplication of a fee schedule;
 - (v) Computer errors;
 - (vi) Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; and
 - (vii) Incorrect data items, such as provider number, use of a modifier or date of service. <Medicare Claims Processing Manual, Chapter 34 § 10.4>

- c. Reopening issues are limited to errors in form and content. Minor omissions that can be addressed as a reopening do not include failure to bill for certain items or services that were not previously billed. <Medicare Claims Processing Manual, Chapter 34 § 10.4>

3. Issues That Cannot Be Reopened

- a. Issues that cannot usually be managed via the telephone reopening process and therefore must proceed through the appeals process include:
 - (i) Claims requiring the input of medical staff or entities outside of the reopening department;
 - (ii) Claims involving limitation on liability;
 - (iii) Medical necessity denials and reductions; or
 - (iv) Issues that require an analysis of documents such as operative reports and clinical summaries. <Medicare Claims Processing Manual, Chapter 34 § 10.5.2>

C. Medicare Claims Appeals Process – Five Levels

1. Contractor Redetermination – The First Level of Appeal

a. Overview

- (i) A physician/practitioner who disagrees with a Contractor's initial determination on a claim may request a Contractor "redetermination." <42 CFR §§ 405.940; Medicare Claims Processing Manual, Chapter 29 § 310>
 - (a) In order to provide some level of independence, the redetermination must be made by someone (typically a Contractor employee) who was not involved in making the initial determination. <42 CFR § 405.948; Medicare Claims Processing Manual, Chapter 29 § 310>

b. Time Frame for Requesting a Redetermination

- (i) In order to obtain a redetermination, the redetermination request must generally be received by the Contractor within 120 days of the date the physician/practitioner received the notice of the initial determination. <42 CFR § 405.946(a) Medicare Claims Processing Manual, Chapter 29 § 310.2>

- (a) In some cases, it may be possible to obtain an extension of the time limit for requesting a redetermination. <42 CFR § 405.946(b); Medicare Claims Processing Manual, Chapter 29 § 310.2>

c. The Redetermination Request

- (i) In order to be effective, a redetermination request must be made using a designated CMS redetermination request form (CMS 20027), or a letter of your own containing all of the following:
 - (a) the beneficiary's name,
 - (b) the Medicare health insurance claim number,
 - (c) the specific items or services for which the redetermination is being requested, including the specific dates of service,
 - (d) the name and signature of the party requesting the redetermination, and
 - (e) An explanation of why the party disagrees with the initial determination and any evidence that the physician/practitioner would like the MAC to consider in making the redetermination. <42 CFR §§ 405.944(b), 405.946; Medicare Claims Processing Manual, Chapter 29 § 310.1.B.2.b>

d. MAC Time Frame for Responding

- (i) Subject to certain limited exceptions, the MAC has 60 calendar days from the receipt of the redetermination request to issue its redetermination decision. <42 CFR § 405.950; Medicare Claims Processing Manual, Chapter 29 § 310.5.A>

2. QIC Reconsideration – The Second Level of Appeal

a. Overview

- (i) A physician/practitioner who disagrees with a Contractor redetermination decision may request "reconsideration" by a "Qualified Independent Contractor" (QIC). <42 CFR § 405.960; Medicare Claims Processing Manual, Chapter 29 § 320>

b. QIC Entities

- (i) The QICs are companies that contract with CMS to perform reconsiderations of Medicare claims as a part of the Medicare appeals process. <Medicare Claims Processing Manual, Chapter 29 § 110>

(a) CMS must contract minimally with four QICs. <42 CFR § 405.902; Medicare Claims Processing Manual, Chapter 29 § 320>

c. Reconsideration Definition

(i) A reconsideration is an independent review of the redetermination. The reconsideration is performed by a panel of individuals with specialized expertise (including, in some cases, physicians). <42 CFR § 405.968; Medicare Claims Processing Manual, Chapter 29 § 320>

d. Time Frame for Requesting a Reconsideration

(i) In order to obtain a reconsideration, the reconsideration request must generally be received by the QIC within 180 days of the date the physician/practitioner received the notice of the redetermination. <42 CFR § 405.962(a); Medicare Claims Processing Manual, Chapter 29 § 320.2>

(a) In some cases, it may be possible to obtain an extension of the time limit for requesting a reconsideration. <42 CFR § 405.962(b); Medicare Claims Processing Manual, Chapter 29 § 320.2>

e. The Reconsideration Request

(i) Information Required

(a) In order to be effective, a reconsideration request must be made using a designated CMS reconsideration request form (CMS 20033), or contain all of the following:

1. the beneficiary's name
2. the Medicare health insurance claim number
3. the specific items or services for which the reconsideration is being requested, including the specific dates of service,
4. the name and signature of the party requesting the reconsideration,
5. the name of the MAC that made the redetermination, and
6. an explanation of why the party disagrees with the redetermination and any evidence that the physician/practitioner would like the QIC to consider in performing the reconsideration. <42 CFR §§ 405.964, 405.966; Medicare Claims Processing Manual, Chapter 29 § 320.1>

(ii) Importance of Providing Complete Information

(a) The failure to provide the QIC with all applicable evidence, including any missing documentation, may preclude subsequent consideration of that evidence. <42 CFR § 405.966>

1. Once the QIC has made the Reconsideration decision, new evidence cannot be submitted to the ALJ without good cause for withholding the evidence from the QIC. <MLN Matters Article MM5554>

(b) It is not necessary to duplicate information that was submitted in the first level Redetermination appeal. The documentation from the Redetermination is forwarded to the QIC. <Medicare Claims Processing Manual, Chapter 29 § 320.5; MLN Matters Article MM5554>

f. QIC Time Frame for Making the Reconsideration Decision

(i) Subject to certain limited exceptions, the QIC has 60 calendar days from the receipt of a timely reconsideration request to issue its decision on the reconsideration. <42 CFR § 405.970; Medicare Claims Processing Manual, Chapter 29 § 320>

(ii) If the QIC is not timely in rendering a decision, you may escalate your appeal to the ALJ level. <42 CFR § 405.970(c)(2); Medicare Claims Processing Manual, Chapter 29 § 330.1>

3. ALJ Appeal – Third Level of Appeal

a. Overview

(i) A physician/practitioner who disagrees with a QIC's reconsideration decision may request a hearing before an administrative law judge (ALJ) if the amount at issue meets the requirement. <42 CFR §§ 405.1002, 405.1006 (b)>

(a) The amount in controversy (AIC) for 2022 must be at least \$180.

1. The amount was \$180 in 2024.

2. The amount was \$180 for 2023

b. How ALJ Hearings Are Conducted

- (i) At an ALJ hearing, the parties may submit evidence, examine witnesses and present legal arguments. A representative of CMS, the Contractor, or the QIC may attend or join the hearing as a party. <42 CFR § 405.1000>
- c. Time Frame for Requesting an ALJ Hearing
- (i) In order to obtain an ALJ hearing, the hearing request must be received by the appropriate entity (see below) within 60 days of receipt of the date that the physician/practitioner received notice of the QIC's reconsideration decision. <42 CFR § 405.1014(b); Medicare Claims Processing Manual, Chapter 29 § 330.2.B>
 - (a) The notice of the QIC reconsideration decision is supposed to specify where to send the request for an ALJ hearing. <42 CFR § 405.1014(b); Medicare Claims Processing Manual, Chapter 29 § 290.4>
- d. The ALJ Hearing Request
- (i) In order to be effective, an ALJ hearing request must be made using a designated CMS ALJ request form (CMS 5011A/B) or contain all of the following:
 - (a) The beneficiary's name, address and Medicare health insurance claim number,
 - (b) The name and address of the appellant,
 - (c) The name and address of any designated representative,
 - (d) The document control number assigned by the QIC,
 - (e) The dates of service,
 - (f) An explanation of why the party disagrees with the QIC's reconsideration decision, and
 - (g) A statement of any additional evidence that should be considered. <42 CFR § 405.1014(a); Medicare Claims Processing Manual, Chapter 29 § 330.2.C>
- e. Time Frame for Issuance of the ALJ Decision
- (i) With some limited exceptions, the ALJ has 90 calendar days from the receipt of a timely ALJ hearing request to issue its decision. <42 CFR § 405.1016; Medicare Claims Processing Manual, Chapter 29 § 330.2.A>

4. Appeals Council Review – Fourth Level of Appeal

a. Overview

- (i) A physician/practitioner who is dissatisfied with the outcome of an ALJ hearing may request a review by the Appeals Council. <42 CFR § 405.1100; Medicare Claims Processing Manual, Chapter 29 § 340>
- (ii) The Appeals Council review is a “de novo” or fresh review of the issue. It looks at the issue anew, rather than simply considering whether the record will support the Contractor’s initial determination. <42 CFR § 1108>
 - (a) A physician/practitioner requesting an Appeals Council review does not have an automatic right to a live hearing. In the absence of a live hearing, the Appeals Council makes its decision based on the written evidence submitted. <42 CFR § 1108>

b. Time Frame for Requesting an Appeals Council Review

- (i) A request for an Appeals Council Review must occur within 60 days of the ALJ’s decision. <Medicare Claims Processing Manual, Chapter 29 § 340>

c. Time Frame for Issuance of an Appeals Council Review Decision

- (i) Generally, the Medicare Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from the ALJ level. <CMS web site: <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/05AppealsCouncil.html>>

5. Judicial (i.e., Court) Review – Fifth Level of Appeal

a. Overview

- (i) A physician/practitioner who is dissatisfied with the outcome of an Appeals Council review may obtain a review by a federal district court if the amount in controversy requirement is met. <42 CFR §§ 405.1136, 405.1006 (c)>
- (ii) The amount remaining in controversy for requests made on or after January 1, 2024, is \$1840.00 < See 88 *Fed. Reg.* 67297>
 - (a) In 2022, the AIC was \$1850.
 - (b) In 2021, the AIC was \$1760.

b. Time Frame for Filing a Judicial Review

- (i) The time limit for filing for judicial review is 60 days from the date of the Appeals Council's decision. <Medicare Claims Processing Manual, Chapter 29 § 240.A>

D. Opportunities for Escalated Review During the Appeals Process

1. Because the appeals process is so lengthy, Congress requires that CMS provide appellants certain opportunities for expedited review of their claims. The appeals process provides the opportunity for physicians/practitioners to escalate their appeal request to a higher level in the following circumstances:
- a. If the QIC fails to complete a reconsideration within the required time frame:
- (i) The QIC must notify the appellant and offer the appellant the opportunity to escalate the appeal to the ALJ.
- (ii) The appellant must notify the QIC in writing if it wishes to escalate the case to the ALJ.
- (iii) Unless the appellant makes a written request to escalate, the QIC will continue the reconsideration process. <42 CFR § 405.970(c)-(e)>
- b. If the ALJ does not issue its decision within the required time frame, the appellant may request an Appeals Council review. <42 CFR § 405.1104>
- c. If the Appeals Council does not issue its decision within the required time frame, the appellant can request escalation to federal court. <42 CFR § 405.1132>

E. Application of the Medicare Guidelines to the Reviewing Bodies

1. The QICs, ALJs and the Appeals Council <42 CFR §§ 405.968(b), 405.1060, 405.1062, 405.1063>
- a. All three reviewing bodies are bound to follow NCDs, CMS rulings and applicable laws.
- b. None of the three reviewing bodies are bound to follow LCDs, LMRPs or CMS program guidance (e.g., manuals, transmittals, etc.).
- (i) The choice to decline to follow a policy does not set a precedent.

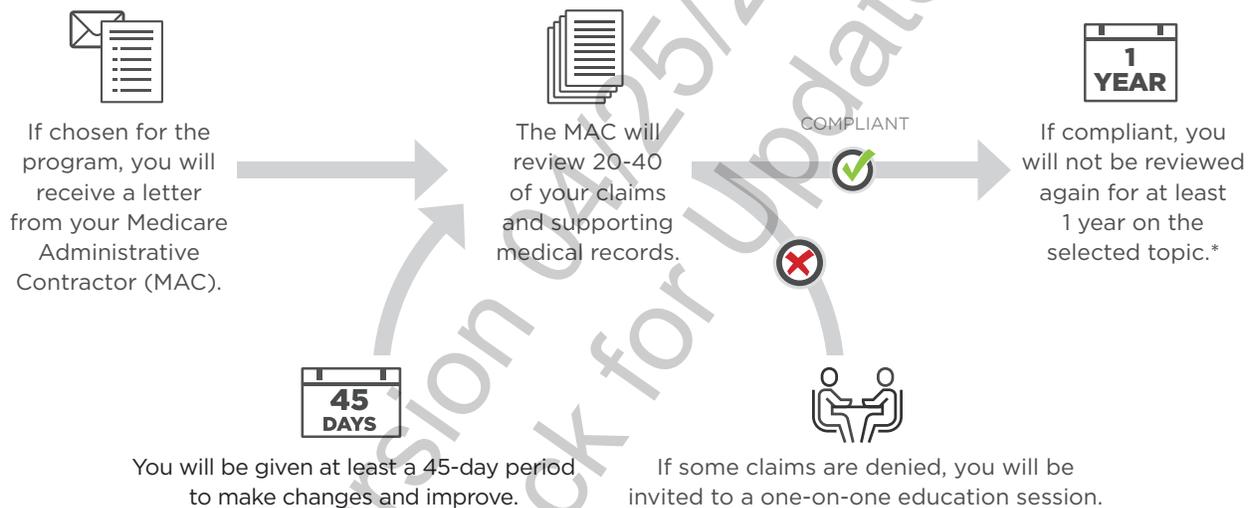
IMPROVING THE MEDICARE CLAIMS REVIEW PROCESS

The **Targeted Probe and Educate (TPE)** program includes one-on-one help to reduce claim errors and denials.

When Medicare claims are submitted accurately, everyone benefits.

Most providers and suppliers will never need TPE. The process is only used with those who have high denial rates or unusual billing practices. If you are chosen for the program, the goal is to help you quickly improve. Often, simple errors - like missing a signature - are to blame. The process is designed to identify common errors in your submissions and help you correct them.

HOW DOES IT WORK?



*MACs may conduct additional review if significant changes in provider billing are detected.

WHAT IF MY ACCURACY STILL DOESN'T IMPROVE?

This should not be a concern for most providers and suppliers. The majority of those that have participated in the TPE process increased the accuracy of their claims. However, any who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.

WHAT ARE SOME COMMON CLAIM ERRORS?

-  The signature of the certifying physician was not included
-  Encounter notes did not support all elements of eligibility
-  Documentation does not meet medical necessity
-  Missing or incomplete initial certifications or recertification

Targeted Probe and Educate (TPE) Q & A's

Q1. What is Targeted Probe and Educate?



A1. When performing medical review as part of Targeted Probe and Educate (TPE), Medicare Administrative Contractors (MACs) focus on specific providers/suppliers that bill a particular item or service rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. TPE involves the review of 20-40 claims per provider/supplier, per item or service. This is considered a round, and the provider/supplier has a total of up to three rounds of review. After each round, providers/suppliers are offered individualized education based on the results of their reviews. Providers/suppliers are also offered individualized education during a round to more efficiently fix simple problems.

Q2. Why is CMS moving to the TPE process for medical review?

A2. The results of previous Probe and Educate (P&E) programs have been well received by the provider/supplier community. Additionally, positive results of the TPE pilot program included a decrease in appeals as well as an increase in provider education which resulted in decreased denial rates for a vast majority of providers as they progressed through the P&E process. These initial P&E programs, however, included all providers/supplier that billed a particular service. In an effort to refine the P&E programs, CMS determined that efforts would be better directed toward those providers/suppliers who, based on data analysis, provide the most risk to the Medicare program, and not to all providers/suppliers billing a particular item/service.

Q4. Why were the TPE sample sizes generally set at 20-40 claims?

A4. The 20-40 claim sample size is intended to allow the MACs to review enough claims to be representative of how accurately providers/suppliers have the necessary supporting documentation to meet Medicare rules and requirements, while not being overly burdensome.

Q7. What happens if there are errors in the claims reviewed?

A7. At the conclusion of each round of 20-40 reviews, providers/suppliers will be sent a letter detailing the results of the reviews and offering a 1-on-1 education session. MACs will also educate providers/suppliers throughout the TPE review process, when easily resolved errors are identified, helping the provider to avoid additional similar errors later in the process. CMS' experience has shown that this education process is well received by providers/suppliers and helps to prevent future errors.

Q8. What should a provider/supplier expect during a 1-on-1 education session?

A8. During a one 1-on-1 education session (usually held via teleconference or webinar), the MAC provider outreach and education staff will walk through any errors in the provider/supplier's 20-40 reviewed claims. Providers/suppliers will have the opportunity to ask questions regarding their claims and the CMS policies that apply to the item/service that was reviewed.

Q9. What is the measurement or error percentage that qualifies a provider as having a "high denial rate"?

A9. The error percentage that qualifies a provider/supplier as having a high denial rate varies based on the service/item under review. The Medicare Fee-For-Service improper payment rate for a specific service/item or other data may be used in this determination, and the percentage may vary by MAC. It is important to note that the determination of whether a provider/supplier moves on to additional rounds of review is based upon improvement from round to round, with education being provided during and after each round in order to help the provider/supplier throughout the process.

Q10. Can claims reviewed as part of the TPE process be appealed? If a claim is appealed and overturned, would this impact the provider denial rate?

A10. The appeals process is unchanged under the TPE process. If a claim denial is appealed and overturned, this would be taken into consideration in subsequent TPE rounds.

Q 12. Under the TPE program, do the MACs send a letter to the provider/supplier with details regarding the results of their reviewed claims?

A12. At the conclusion of each round of review, the MAC sends the provider/supplier a letter detailing the results of the 20-40 claims reviewed during that round, including details regarding claim errors. This letter may be sent before or after the final one-on-one educational call.

Q13. Is the education provided each round provider/supplier-specific or general education given to all providers/suppliers?

A13. The education session in each round is developed based on the review findings from the most recently completed round of reviews and is not the same unless errors found in the reviewed claims are the same. The education will reinforce corrections that should be made for errors that continue to be identified in subsequent rounds.

Q 14. Will previous Probe and Educate (P&E) review results be used to identify providers who will be included in TPE?

A14: CMS is encouraging MACs to use all available sources of data when selecting providers to include in the TPE process. The results of previous P&E programs is one source of data that MACs will use to select providers for review. MACs will also use provider billing and utilization patterns as well as provider specific error rates. Using the results of previous P&E programs may be of benefit to many

HHAs who improved throughout the P&E process, as these providers may not require additional reviews.

Q15: Does CMS plan to share specific data from the Home Health P&E program?

A15: While CMS does not have detailed Home Health P&E data available to the public, general results information is available on the [Home Health Medical Review webpage](#). The most common errors identified during the P&E process were issues related to the Face to Face requirements; including no signature by the certifying physician and encounter notes not supporting all of the elements of eligibility, and recertification with no estimate of continued need for service or with missing or incomplete or initial certifications. These common errors are ones that CMS believes can be effectively addressed through provider education.

Version 04/25/2024
Check for Updates

III. Evaluation of Deeming Authority Request

The Joint Commission submitted all the necessary materials to enable us to make a determination concerning its request for continued approval of its psychiatric hospital accreditation program. This application was determined to be complete on July 30, 2022. Under section 1865(a)(2) of the Act and our regulations at § 488.5 (Application and re-application procedures for national accrediting organizations), our review and evaluation of The Joint Commission will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of The Joint Commission's standards for psychiatric hospitals as compared with CMS' psychiatric hospital CoPs.

- The Joint Commission's survey process to determine the following:

- ++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.

- ++ The comparability of the Joint Commission's processes to those of state agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

- ++ The Joint Commission's processes and procedures for monitoring a psychiatric hospital found out of compliance with the Joint Commission's program requirements. These monitoring procedures are used only when the Joint Commission's identifies noncompliance. If noncompliance is identified through validation reviews or complaint surveys, the state survey agency monitors corrections as specified at § 488.9(c).

- ++ The Joint Commission's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

- ++ The Joint Commission's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

- ++ The adequacy of the Joint Commission's staff and other resources, and its financial viability.

- ++ The Joint Commission's capacity to adequately fund required surveys.

- ++ The Joint Commission's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

- ++ The Joint Commission's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving

individuals who conduct surveys or participate in accreditation decisions.

- ++ The Joint Commission's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as we may require (including corrective action plans).

IV. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

V. Response to Public Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document on September 8, 2022, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: September 27, 2022.

Lynette Wilson,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2022–21305 Filed 9–28–22; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–4200–N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2023

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2023. The calendar year 2023 AIC threshold amounts are \$180 for ALJ hearings and \$1,850 for judicial review.

DATES: This annual adjustment takes effect on January 1, 2023.

FOR FURTHER INFORMATION CONTACT: Liz Hosna, (410) 786–4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act) established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review at \$100 and \$1,000, respectively, for Medicare Part A and Part B appeals. Additionally, section 1869(b)(1)(E) of the Act provides that beginning in January 2005, the AIC threshold amounts are to be adjusted annually by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved and rounded to the nearest multiple of \$10. Sections 1852(g)(5) and 1876(c)(5)(B) of the Act apply the AIC adjustment requirement to Medicare Part C/ Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement, pursuant to 42 CFR 417.840. Section 1860D–4(h)(1) of the Act, provides that a Medicare Part D plan sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) of the Act with respect to benefits, including appeals and the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations at § 405.1006(b)(2) require the Secretary of Health and

Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register**. In order to be entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at § 405.1006(b). Similarly, a party must meet the AIC requirements at § 405.1006(c) at the time judicial review is requested for the court to have jurisdiction over the appeal (§ 405.1136(a)).

B. Medicare Part C/MA Appeals

Section 1852(g)(5) of the Act applies the AIC adjustment requirement to Medicare Part C appeals. The implementing regulations for Medicare Part C appeals are found at 42 CFR 422, subpart M. Specifically, sections 422.600 and 422.612 discuss the AIC threshold amounts for ALJ hearings and judicial review. Section 422.600 grants any party to the reconsideration (except the MA organization) who is dissatisfied with the reconsideration determination a right to an ALJ hearing as long as the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary. Section 422.612 states, in part, that any party, including the MA organization, may request judicial review if the AIC meets the threshold requirement established annually by the Secretary.

C. Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

Section 1876(c)(5)(B) of the Act states that the annual adjustment to the AIC dollar amounts set forth in section 1869(b)(1)(E)(iii) of the Act applies to certain beneficiary appeals within the context of health maintenance organizations and competitive medical

plans. The applicable implementing regulations for Medicare Part C appeals are set forth in 42 CFR 422, subpart M and apply to these appeals in accordance with 42 CFR 417.600(b). The Medicare Part C appeals rules also apply to health care prepayment plan appeals in accordance with 42 CFR 417.840.

D. Medicare Part D (Prescription Drug Plan) Appeals

The annually adjusted AIC threshold amounts for ALJ hearings and judicial review that apply to Medicare Parts A, B, and C appeals also apply to Medicare Part D appeals. Section 1860D-4(h)(1) of the Act regarding Part D appeals requires a prescription drug plan sponsor to meet the requirements set forth in sections 1852(g)(4) and (g)(5) of the Act, in a similar manner as MA organizations. The implementing regulations for Medicare Part D appeals can be found at 42 CFR 423, subparts M and U. More specifically, § 423.2006 of the Part D appeals rules discusses the AIC threshold amounts for ALJ hearings and judicial review. Sections 423.2002 and 423.2006 grant a Part D enrollee who is dissatisfied with the independent review entity (IRE) reconsideration determination a right to an ALJ hearing if the amount remaining in controversy after the IRE reconsideration meets the threshold amount established annually by the Secretary, and other requirements set forth in § 423.2002. Sections 423.2006 and 423.2136 allow a Part D enrollee to request judicial review of an ALJ or Medicare Appeals Council decision if the AIC meets the threshold amount established annually by the Secretary, and other requirements are met as set forth in these provisions.

II. Provisions of the Notice—Annual AIC Adjustments

A. AIC Adjustment Formula and AIC Adjustments

Section 1869(b)(1)(E)(iii) of the Act requires that the AIC threshold amounts be adjusted annually, beginning in January 2005, by the percentage increase in the medical care component of the CPI for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of \$10.

B. Calendar Year 2023

The AIC threshold amount for ALJ hearings will remain at \$180 and the AIC threshold amount for judicial review will rise to \$1,850 for CY 2023. These amounts are based on the 84.665 percent increase in the medical care component of the CPI, which was at 297.600 in July 2003 and rose to 549.562 in July 2022. The AIC threshold amount for ALJ hearings changes to \$184.66 based on the 84.665 percent increase over the initial threshold amount of \$100 established in 2003. In accordance with section 1869(b)(1)(E)(iii) of the Act, the adjusted threshold amounts are rounded to the nearest multiple of \$10. Therefore, the CY 2023 AIC threshold amount for ALJ hearings is \$180.00. The AIC threshold amount for judicial review changes to \$1,846.65 based on the 84.665 percent increase over the initial threshold amount of \$1,000. This amount was rounded to the nearest multiple of \$10, resulting in the CY 2023 AIC threshold amount of \$1,850.00 for judicial review.

C. Summary Table of Adjustments in the AIC Threshold Amounts

In the following table we list the CYs 2019 through 2023 threshold amounts.

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
ALJ Hearing	\$160	\$170	\$180	\$180	\$180
Judicial Review	1,630	1,670	1,760	1,760	1,850

III. Collection of Information Requirements

This document does not impose any “collection of information” requirements as defined under 5 CFR 1320.3(c). Consequently, the notice is not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the

Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: September 27, 2022.
Vanessa Garcia,
Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2022-21284 Filed 9-29-22; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

[CFDA Number: 93.568]

Proposed Reallotment of Fiscal Year 2021 Funds for the Low Income Home Energy Assistance Program

AGENCY: Office of Community Services (OCS), Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

Medicare Claims Processing Manual

Chapter 34 - Reopening and Revision of Claim Determinations and Decisions

(Rev. 4219, 01-25-19)

Table of Contents

Transmittals for Chapter 34

- 10 - Reopenings and Revisions of Claim Determinations and Decisions - General
 - 10.1 - Authority to Conduct a Reopening
 - 10.2 - Refusal to Reopen is Not an Initial Determination
 - 10.3 - Reopening of Denials Based on an Unanswered ADR Request
 - 10.4 - Reopenings Based on Clerical or Minor Errors and Omissions
 - 10.4.1 - Providers Submitting Adjustments
 - 10.5 - Telephone Reopenings – Required for A/B MACs (B) Only
 - 10.5.1 - Informing the Provider Communities About the Telephone Reopenings Process
 - 10.5.2 - Issues for Telephone Reopenings
 - 10.5.3 - Conducting the Telephone Reopening
 - 10.5.4 - Documenting the Telephone Reopening
 - 10.5.5 – Monitoring the Telephone Reopening
 - 10.6 - Timeframes to Reopen Claim Determinations
 - 10.6.1 - Timeframes for Contractor Initiated Reopenings
 - 10.6.2 - Timeframes for Party Requested Reopenings
 - 10.6.3 - Timeframes for Adjudicator to Reopen
 - 10.6.4 - Timeframes When a Party Requests an Adjudicator Reopen Their Decision
 - 10.7 - Timeframes to Complete a Reopening Request by a Party
 - 10.8 - Notice of a Revised Determination or Decision
 - 10.9 - Revised Determination or Decision
 - 10.10 - Effect of a Revised Determination or Decision
 - 10.11 - Good Cause for Reopening

10.11.1 - What Constitutes New and Material Evidence

10.11.2 – Policies Related to Good Cause Reopenings for New and Material Evidence

10.11.3 – What Constitutes Error on the Face of the Evidence

10.12 - Change in Substantive Law or Interpretative Policy

10.13 – System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities

Version 04/25/2024
Check for Updates



10 - Reopenings and Revisions of Claims Determinations and Decisions - General

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process. Reopenings are a discretionary action on the part of the contractor. A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not toll the timeframe to request an appeal. If the reopening action results in a revised determination, then new appeal rights would be offered on that revised determination. Under certain circumstances a party may request a reopening even if the timeframe to request an appeal has not expired.

Historically, contractors have employed a variety of informal procedures under the general heading of "reopenings," "re-reviews," "informal redeterminations," etc.

Providers, physicians and suppliers may have come to view these as appeal rights. However, as stated above, reopenings are separate and distinct from the appeals process. They are not a party's right. Contractors shall not use them to provide an appeal when a formal appeal is not available. Contractors should also note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) recovery claims where the debtor is the beneficiary or provider/supplier are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim because the provider/supplier failed to file a proper claim as defined in 42 CFR Part 411. Aside from this one exception, MSP recovery claims involve recovery of the insurance funds at issue, not recovery of the payment previously made by Medicare. Consequently, the recovery action does not involve the reopening of Medicare's payment determination. The MSP recovery demand letter is an "initial determination" as defined in 42 CFR 405.924, not a reopening and revision of Medicare's initial claims payment determination.

10.1 - Authority to Conduct a Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Reopenings can be conducted by a contractor to revise an initial determination, revised initial determination or redetermination; a Qualified Independent Contractor (QIC) to revise a reconsideration; an Administrative Law Judge (ALJ) to revise a hearing decision, and the Appeals Council (AC) to revise an ALJ decision or their own review decision.

Reopenings are generally not conducted until a party's appeal rights have been exhausted or the timeframe to file a request for an appeal has expired. There are two exceptions that

allow a reopening to be conducted when appeal rights have not been exhausted or the timeframe to request an appeal has not expired. These exceptions are:

- Cases where Medical Review (MR) requested documentation, did not receive it, and issued a denial based on no documentation (i.e., Group Code: CO - Contractual Obligation; Claim Adjustment Reason Code (CARC) 50 - these are non-covered services because this is not deemed a “medical necessity” by the payer; and Remittance Advice Remark Code (RARC) M127 - Missing patient medical record for this service). Subsequently, if the party requests an appeal and submits the requested documentation with that appeal, it shall be treated as a reopening; and
- Clerical errors (which includes minor errors and omissions) shall be treated as reopenings.

If a contractor receives a valid and timely request for redetermination and begins processing the request as a reopening (clerical error or otherwise) and later determines that a reopening cannot be performed, or the determination cannot be changed, the contractor shall not issue a refusal to reopen notice. Rather, the contractor shall process the request as a valid/timely redetermination (as originally requested by the party) in accordance with Pub. 100-04, chapter 29.

If a party has filed a valid request for an appeal, the adjudicator at the lower levels of the appeals process loses jurisdiction to reopen the claim on the issues in question. For example, a party simultaneously requests a QIC reconsideration and a reopening with the contractor. The contractor can no longer reopen that redetermination decision now that the party has filed a valid request for QIC reconsideration. This does not preclude contractors from accepting and processing remands from the QIC.

As stated previously, it is within the contractor’s discretion to accept reopening requests, but once accepted, they must be processed in accordance with the above instruction.

10.2 - Refusal to Reopen Is Not an Initial Determination (Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

A finding that a prior determination or decision will not be reopened is not an “initial determination or decision.” A contractor’s choice not to reopen is not appealable. Accordingly, the contractor shall not include a statement concerning the right to an appeal in the notice informing the party that their reopening request cannot be processed. A party may however request an appeal on the original claim denial, but must do so within the required timeframes. If a contractor receives a reopening request and does not believe they can change the determination, they should not process the request.

10.3 - Reopenings of Denials Based on an Unanswered Additional Documentation Request (ADR) (Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

If a claim is suspended for medical review, an ADR may be issued to obtain information needed to make a determination. Providers, physicians, and suppliers are responsible for providing the information needed to adjudicate their claims. If no response is received to the ADR within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on a lack of documentation.

If such a denial is appealed, the Medical Review department at the contractor shall perform a reopening instead of an appeal if all of the following conditions are met:

- 1) A provider failed to timely submit documentation requested through an ADR;
- 2) The claim was denied because the requested documentation was not received timely;
- 3) The requested documentation is received after the 45 day period with or without a request for redetermination or reopening; AND,
- 4) The request is filed within 120 days of the date of receipt of the initial determination.

If all 4 criteria are not present, the request is for a redetermination and it is submitted within 120 days of the date of receipt of the initial determination, handle it as an appeal and do not ship the case back to MR. In this instance, the request must meet the criteria for a valid request for redetermination (see Pub. 100-04, Chapter 29, §310.1) in order for the appeals unit to accept the request.

The CMS is handling these requests outside of the appeals process because CMS wants to encourage providers, physicians and suppliers to submit documentation when requested in order to prevent unnecessary appeals. Contractors should note that this requirement does not extend the time frame for filing an appeal. Therefore, only those appeal requests that are submitted within 120 days of the date of receipt of the initial determination and meet all of the criteria above should be shipped back to MR for a reopening. When the appeals unit ships cases back to the MR unit, MR must reopen those cases.

If the request is submitted after 120 days, contractors may grant a regular reopening at their discretion or dismiss the request if no good cause explanation is provided for the late filing.

If the ADR reopening results in an affirmation of the original denial or an adverse decision, the provider will retain their right to a redetermination. The date of the MR decision will be the date used to calculate the 120 days to request a redetermination.



10.4 - Reopenings Based on Clerical or Minor Errors and Omissions (Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Section 937 of the Medicare Modernization Act (MMA) required CMS to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. We equate the MMA's minor error or omission to fall under our definition of clerical error, located in 42 CFR 405.980(a)(3). We believe that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, 42 CFR 405.927 and 405.980(a)(3) require that clerical errors be processed as reopenings rather than appeals. CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors; or,
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate.
- Incorrect data items, such as provider number, use of a modifier or date of service.

Note that clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. A contractor shall not grant a reopening to add items or services that were not previously billed, with the exception of a few limited items that cannot be filed on a claim alone (e.g., G0369, G0370, G0371 and G0374). Third party payer errors do not constitute clerical errors.

The law provides that reopenings may be done to correct minor errors or omissions, that is, clerical errors. The contractor has discretion in determining what meets this definition and therefore, what could be corrected through a reopening.

10.4.1 - Providers Submitting Adjustments

(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

Part A providers that are able to submit an adjusted or corrected claim to correct an error or omission may continue to do so and are not required to request a reopening. Additionally, we encourage A/B MACs (A) and (HHH) who were handling the corrections of such errors by advising providers to submit adjusted claims to instruct providers that submitting adjusted claims continues to be the most efficient way to correct simple errors.

10.5 - Telephone Reopenings - Required for A/B MACs (B) Only (Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)



NOTE: Since most A/B MACs (A) and (HHH) never processed telephone redeterminations, CMS does not expect that A/B MACs (A) and (HHH) will process many telephone reopenings, if any. However, they are not precluded from doing so, should the telephone process prove effective. If A/B MACs (A) and (HHH) choose to process telephone reopenings, they will be held to the same standards.

The majority of appeals processed as telephone redeterminations consisted of minor or clerical errors that could be quickly corrected over the telephone. Section 937 of MMA required CMS to establish a process to correct such errors outside of the appeals process. Therefore, CMS has discontinued telephone redeterminations that were formerly processed by A/B MACs (B) and DME MACs and has implemented the telephone reopenings process. CMS believes that the vast majority of the work processed as telephone redeterminations can instead be processed as telephone reopenings. A small percentage of the work processed under telephone redeterminations will now fall under written redeterminations and stay within the purview of the appeals units.

A/B MACs (B) and DME MACs shall allocate costs of reopenings that would have formerly been processed as a telephone redetermination, but fall under the definition of a clerical error under the claims reopenings Budget & Performance Requirements (BPR) Code (11210). ADR reopenings that are shipped back to MR should be counted in the appropriate MR BPR code.

The following sections describe the procedures for accepting and processing reopenings over the telephone. CMS believes that most telephone reopenings will consist of clerical errors or omissions that can be corrected quickly and easily over the telephone. That does not preclude contractors from processing written requests for clerical error reopenings. They may handle such requests either by phone or in writing.

Whether a request for reopening is made by telephone or is conducted and completed as a telephone reopening depends on the issues at hand and the complexity of the matters involved.

Receiving reopening requests and conducting reopenings on the telephone should expedite and simplify the process. Requesting a reopening on the telephone provides quick and easy access to parties who wish to correct clerical errors or omissions.

The contractor shall ensure that the Privacy Act of 1974, 5 USC, §552a, is applied to its telephone reopening process. All staff that perform telephone reopenings shall be trained on the Privacy Act requirements (see Pub. 100-01, chapter 6, Disclosure of Information).

10.5.1 - Informing the Provider Communities About the Telephone Reopenings Process

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

The contractor shall inform providers, physicians, and other suppliers of its telephone reopenings process 30 days prior to initiation and annually thereafter or when making significant changes to its process. It shall provide information about its process through means such as Web sites, bulletins/newsletters, customer service/inquiry and provider relations departments, conduct seminars, etc.

Information it publishes about its telephone reopenings 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 should state that he/she is requesting a telephone reopening;
- Type of documentation that the party should have on hand when calling in to request a reopening;
- The types of issues the contractor might be able to handle over the telephone and the types of issues it will not handle over the telephone. Please see §10.5.2 below for further discussion of issues that are appropriate for telephone reopenings.

10.5.2 - Issues for Telephone Reopenings

(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)



Telephone reopenings shall be limited to resolving minor issues and correcting errors as defined in §10.4. As necessary, the contractor may ask the provider, physician, or supplier to fax in documentation to support changes and error correction. If it appears extensive documentation is required for review, please inform the requestor that they should file a written request for reopening or file a request for an appeal, if applicable.

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

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

Contractors are not precluded from conducting a reopening on the issues listed above. However, CMS believes that the issues above are usually too complex to be handled appropriately over the phone in most instances.

In all cases, telephone reopenings are **inappropriate** for the following issues: Claims requiring the input of medical staff or other entities outside of the reopenings department and “big box” cases.

A. Issues That Can Not be Resolved During the Telephone Reopening

There may be instances where an issue cannot be resolved during the telephone reopening. An issue may not be resolvable on the telephone because: (1) the issue becomes too complex to be handled over the telephone and/or it is in the best interest of the party to have a more in-depth review performed; or (2) there is a need for additional medical documentation from the provider, physician, or other supplier.

If the issue cannot be resolved due to one of the preceding reasons, the contractor advises the party that the reopening cannot be handled over the telephone. The contractor shall instruct the party to either file a written request for reopening or file a written request for appeal. Instruct the party that appeal requests must be filed within 120 days from the date of the initial determination.

10.5.3 - Conducting the Telephone Reopening

(Rev. 4219, Issued: 01-25-19, Effective: 02-26-19, Implementation: 02-26-19)



The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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

- Verify the provider's/physician's/supplier's name and identification number or National Supplier Clearinghouse number;
- Beneficiary last name, first initial; and
- *Medicare number.*

Items must match exactly.

The contractor should also inform the caller that the call may be monitored for quality assurance.

The following items shall be obtained/recorded/confirmed during telephone reopening:

- Date of call;

- Name of caller;
- Phone number of the party;
- Name of provider/physician/supplier of item or service;
- Dates of service;
- Which items(s) or service(s) are at issue;
- Reason for the request;
- Any new information that is received during the telephone call;
- Rationale for not processing the request, if applicable;
- Any appeal rights, if applicable;
- Name of the reviewer;
- Confirmation number, if applicable; and
- Inform the caller that the call may be monitored.

10.5.4 - Documenting the Telephone Reopening

(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

The information received during the telephone reopening (especially the date of the call) must be either: (1) documented on a reopening documentation form; or (2) logged into the contractor's computer system.

All documentation must be assigned a control number. Any additional documentation received must be recorded into the contractor system or attached to the form. The telephone reopening control number is recorded on all documents received that are associated with the telephone reopening, if applicable. The documents are included in the file.

Although documentation should rarely be necessary during a telephone reopening, the documentation must be made a part of the file and be available if an appeal is requested based on any revised determination issued as a result of the reopening. All documentation should be maintained in a manner that allows for future audits.

10.5.5 - Monitoring the Telephone Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

CMS may review this function at any time so the contractor may want to develop and maintain records on a monitoring/quality assurance process.

10.6 - Timeframes to Reopen Claim Determinations

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

Our regulations establish timeframes that restrict the ability of the contractor to reopen claim determinations. See 42 CFR 405.980(b) and (c) for the timeframes for reopenings. The specific timeframes for contractor-initiated and party-requested reopenings are detailed below.

10.6.1 - Timeframes for Contractor Initiated Reopenings

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A contractor may reopen and revise its initial determination or redetermination on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in §10.11; or
- At any time if:
 - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in 42 CFR 405.902; or
 - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error as defined in §10.4; or,
- At any time to effectuate a coverage decision issued under 42 CFR 426.460(b)(1)(i), 426.488(b) and (c) or 426.560 (b)(1)(i) appeals process.

10.6.2 - Timeframes for Party Requested Reopenings

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A party may request a contractor reopen and revise its initial determination or redetermination under the following conditions:

- Within 1 year from the date of the initial determination or redetermination for any reason; or

- Within 4 years from the date of the initial determination or redetermination for good cause as defined in §10.11; or,
- At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error as defined in §10.4.

While a contractor can reopen at any time under the limited criterion set forth above to correct an unfavorable determination, CMS does not expect that a contractor would regularly grant these requests, especially for older claims where the claims history is not readily available. Both the contractor and the provider/physician/supplier have a reasonable expectation to administrative finality in the processing of their claims. Additionally, administrative efficiency and the ability of a Medicare contractor to continue vital functions (i.e., process Medicare claims and process appeal requests) require that contractors grant such requests rarely.

10.6.3 - Timeframes for Adjudicator to Reopen (Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)A

QIC, ALJ or the AC may reopen and revise its reconsideration, hearing decision or review, respectively, under the following conditions:

- Within 180 days from the date of its decision for good cause in accordance with 42 CFR 405.986; or,
- At any time if the reconsideration, hearing decision or review was procured by fraud or similar fault.

10.6.4 - Timeframes When a Party Requests an Adjudicator Reopen Their Decisions (Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A party may request a QIC, ALJ or the AC reopen and revise its reconsideration, hearing decision or review within 180 days from the date of the reconsideration, hearing decision or review, as applicable, for good cause in accordance with 42 CFR 405.986.

10.7 - Timeframes to Complete a Reopening Requested by a Party (Rev. 2241; Issued: 06-17-11, Effective: 10-01-11, Implementation: 10-03-11)

There are no timeframes established in statute or regulation governing the timeframes for a contractor to complete a reopening action. However, a party to an initial determination has a reasonable expectation to the administrative finality of a determination issued by Medicare. Therefore, this section sets out timeframes to complete the reopening action once the reopening has been initiated. These timeframes apply only to those reopening

requests that are requested by the party to the initial determination. These timeframes do not apply to contractor initiated reopenings.

For those reopenings requested by a party that the contractor agrees to reopen, the contractor shall complete the reopening action 60 days from the date of receipt of the party's reopening request in the corporate mailroom, receipt in a secure Internet portal/application, or receipt of the telephone request. This does not apply to "big box cases" defined as aggregated requests filed by a provider, physician, or other supplier that involve 40 or more beneficiaries/claims and \$40,000 or more in controversy.

10.8 - Notice of a Revised Determination or Decision

(Rev. 2241; Issued: 06-17-11, Effective: 10-01-11, Implementation: 10-03-11)

If the reopening action results in a revised determination or decision that results in payment to a provider, physician, or supplier, a revised electronic or paper remittance advice notice must be issued by the Medicare contractor and will satisfy the notice requirements. If applicable, a revised Medicare Summary Notice will suffice for notice to the beneficiary in the above instances. If the reopening action results in an adverse revised determination or decision the contractor shall mail, or if approved by CMS, transmit via a secure Internet portal/application a letter that states the rationale and basis for the reopening and revision and any right to appeal. The timeframe to request the appeal would be based on the date of the contractor's revised determination. If the contractor cannot change the original determination or chooses to not accept the request, the contractor should inform the requestor that the contractor cannot process their reopening request. If the request is over the telephone, the contractor can verbally inform the caller that they cannot process their request. If it is a written reopening request submitted via hard copy or a secure Internet portal/application, the contractor shall send a brief letter via mail or, if approved by CMS, a secure Internet portal/application, informing the requestor that they cannot process the request. The contractor should state that their decision to not reopen a claim determination is not an initial determination and is therefore not appealable.

10.9 - Revised Determination or Decision

(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

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 allowable 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 a claim previously disallowed because the services were not medically necessary and therefore subject to the limitation on liability provisions, is now to be disallowed on a basis that precludes consideration of limitation on liability).

10.10 - Effect of a Revised Determination or Decision

(Rev. 1069, Issued: 09-29-06, Effective: 11-29-06, Implementation: 11-29-06)

The revision of an initial determination is binding on all parties unless a party files a written request for a redetermination of the revised determination that is accepted and processed. The request for a redetermination must be filed within 120 days from the date of the revised initial determination. The revision of a redetermination is binding on all parties unless a party files a written request for a QIC reconsideration that is accepted and processed.

10.11 - Good Cause for Reopening

(Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

On its own initiative or at the request of party (see IOM Pub. 100-04, chapter 29, §110 for the definition of a party), a contractor may reopen an initial determination or redetermination within 4 years from the date of the initial determination or redetermination when good cause exists. However, good cause is not required for reopening of claims for up to 1 year from the date of the initial determination or redetermination. Under 42 CFR 405.986, good cause exists when:

- There is new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion; or
- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

A contractor's decision to reopen based on the existence of good cause, or refusal to reopen after determining good cause does not exist, is not subject to appeal. See 42 CFR 405.926(l), and 405.980(a)(5).

NOTE: Third party payer error in making a primary payment determination does not constitute good cause for the purposes of reopening an initial determination or redetermination when Medicare processed the claim in accordance with the information in its system of records or on the claim form. Contractors may only reopen for third party payer error under the “within one year for any reason” standard. This is true for both contractor initiated reopenings as well as reopenings requested by a party. All providers and suppliers have a legal obligation to determine the correct primary payer when billing Medicare. Failure to do so, regardless of third party payer error, does not constitute “good cause” that will permit reopening beyond one year. Information regarding such error does not constitute “new and material evidence.”

10.11.1 - What Constitutes New and Material Evidence

(Rev. 1671, Issued: 01-16-09; Effective/Implementation Date: 02-16-09)



New and material evidence is one of the means for establishing good cause to reopen an initial determination or redetermination. New and material evidence is evidence that:

1. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination or redetermination; and
2. May result in a conclusion different from that reached in the initial determination or redetermination.

For example, data analysis that identifies a high error rate or pattern of potential overutilization on the part of a provider or supplier is one example of evidence that is not readily available or known to a contractor at the time it made its initial determination, and may cause the contractor to believe its initial determinations for the claims of the provider or supplier were incorrect.

Evidence may include any record used in the provision of medical care that supports whether or not the service was covered, medically necessary, and provided as billed. This includes medical records, progress notes, orders, procedure reports, invoices, proofs of delivery, or other documentation as required by CMS policy. However, as explained further below, any such evidence submitted by a party must satisfy the good cause standard set forth in §405.986 (i.e., that it is new and material evidence (as described above), or demonstrates that the evidence considered in making the initial determination or redetermination clearly shows on its face that an obvious error was made at the time of the determination or decision).

10.11.2 - Policies Related to Good Cause Reopenings for New and Material Evidence

(Rev. 1671, Issued: 01-16-09; Effective/Implementation Date: 02-16-09)



In determining whether good cause exists for reopening an initial determination or redetermination, the contractor considers whether evidence is new and material from the perspective of the person or entity requesting or initiating the reopening.

When a party requests a reopening of an initial determination or redetermination for good cause based on the submission of new and material evidence, the following policies apply:

- The mere submission of additional evidence is not necessarily sufficient to establish good cause to reopen an initial determination or decision. The information must be “new,” (i.e., not readily available or known to exist at the time of the initial determination) as well as material (i.e., may result in a different conclusion). A party should explain how the information constitutes new and material evidence that establishes good cause. If the contractor is unable to determine whether the information submitted with a reopening request constitutes new and material evidence, the contractor may decide not to grant the reopening.

- When a request for reopening is submitted with new and material evidence, but additional information or evidence is needed before a proper revised determination or decision can be made, the contractor may contact the party seeking the reopening, and request that they obtain and submit the additional information. If the person or entity requesting the reopening cannot obtain the additional information, the Medicare contractor assists to the extent that it is reasonably able to do so.

When a Medicare contractor initiates a reopening of an initial determination or redetermination for good cause based on the existence of new and material evidence, the following policies apply:

- The contractor is responsible for clearly documenting in the case file the new and material evidence that represents good cause for reopening.
- In order to promote administrative efficiency, Medicare does not generally require that a party submit supporting medical documentation with the initial claim. Therefore, if a medical record or other supporting documentation was not utilized when a contractor made an initial determination, because it was not requested or was not provided, then the content of any medical records or supporting documentation which are subsequently requested by the contractor during the course of its review would constitute new evidence.

10.11.3 - What Constitutes Error on the Face of the Evidence (Rev. 1671, Issued: 01-16-09; Effective/Implementation Date: 02-16-09)

Error on the 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 the contractor's Medicare file or in CMS files at the time such determination or decision was made.

10.12 - Change in Substantive Law or Interpretative Policy (Rev. 3568, Issued: 07-29-16, Effective: 09-30-16, Implementation: 09-30-16)

A change of legal interpretation or policy by CMS in a regulation, CMS ruling or CMS general instruction, or a change in legal interpretation or policy by SSA in a regulation, SSA ruling or SSA general instruction in entitlement appeals, whether made in response to judicial precedent or otherwise, is not a basis for reopening a determination or decision under this section. This provision does not preclude contractors from conducting reopenings to effectuate coverage decisions issued under 42 CFR 42 CFR §426.460(b)(1)(i), 426.488 (b) and (c), or 426.560(b)(1)(i) appeals process..

10.13 – System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities (Rev. 2241; Issued: 06-17-11, Effective: 10-01-11, Implementation: 10-03-11)

Contractors who develop and utilize a secure Internet portal/application for reopening purposes shall ensure, at a minimum:

- CMS approves (i.e., Contract Manager or Project Officer, if applicable, and Appeals Business Function Lead) the proposed portal/application and usage prior to development and implementation.
- The portal/application fully complies and has been tested to ensure compliance with all CMS system security requirements regarding protected health information prior to implementation/usage.
- The secure Internet portal/application includes a formal registration process that validates the signature. This process shall include, at a minimum, use of restricted user identifiers (IDs) and passwords. Contractors shall include an indication and/or description of the validation methodology in the appeals case file should an appeal on the item/service reopened be requested.
- Templates for submission of electronic reopening request shall include, at a minimum, a method for authenticating that the party has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application shall provide education to parties to the reopening regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- Contractors shall also educate parties to the reopening that participation/enrollment in the secure portal/application is at the discretion of the party and the party bears the responsibility for the authenticity of the information being attested to.
- Appropriate procedures are in place to provide parties with confirmation of receipt of the reopening request via secure Internet/portal and verbiage instructing the parties not to submit additional reopening requests for the same item or service via different venue (hard copy mail or telephone).
- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which a party can submit additional documentation/materials concurrent with the reopening request. The portal/application shall have the capability to accept additional documentation and/or other materials to support reopening requests.
- Refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements as outlined in the Pub. 100-04, chapter 34. In addition, contractors shall provide hard copy decision notices to parties to the reopening, as required,

who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).

- Contractors utilizing a secure Internet portal/application shall include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.
- Contractors shall also ensure that parties may save and print the revised adverse determination/decision notice or refusal to reopen notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision notices so as to adequately inform the party of timeframes for ensuring timely submission of future appeal requests.

Version 04/25/2024
Check for Updates

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 853	Date: January 4, 2019
	Change Request 10641

SUBJECT: Updates to the Appeals Prioritization Process

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 3 of Publication (Pub.) 100-08 to account for recent enhancements to the prioritization process for contractor selection and participation in Administrative Law Judge (ALJ) Hearings.

EFFECTIVE DATE: February 5, 2019

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

IMPLEMENTATION DATE: February 5, 2019

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-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.9/Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings
R	3/3.9/3.9.1/Election of Status

III. FUNDING:**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**

Attachment - Business Requirements

Pub. 100-08	Transmittal: 853	Date: January 4, 2019	Change Request: 10641
-------------	------------------	-----------------------	-----------------------

SUBJECT: Updates to the Appeals Prioritization Process

EFFECTIVE DATE: February 5, 2019

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

IMPLEMENTATION DATE: February 5, 2019

I. GENERAL INFORMATION

A. Background: This CR updates Chapter 3 of Pub. 100-08 instructions related to contractor participation in ALJ Hearings to account for recent updates in the prioritization process, including the shift in oversight responsibility to the Administrative Qualified Independent Contractor (AdQIC) and the creation of a portal system for contractor selection of desired participant roles.

B. Policy: This CR does not involve any legislative, statutory, or regulatory changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10641.1	Contractors shall adhere to the instructions outlined in Pub. 100-08, Chapter 3, Section 3.9 to utilize the prioritization process and take a participant status for appeals pending at the Office of Medicare Hearings and Appeals. NOTE: While these business requirements emphasize the updated or added Pub.100-08 text, Contractors are reminded to review this section and pertinent regulatory citations in their entirety, to ensure compliance with the ALJ process.	X	X	X	X					
10641.2	Contractors requesting 'leave' of an ALJ--or formally requesting to be a secondary party in the hearing-- shall be aware that such process exists outside of the AdQIC portal.	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10641.2.1	Contractors should elect to participate as a participant or as a witness if their request for leave is denied.	X	X	X	X					
10641.3	Contractors who are interested in acting as a witness should indicate their interest via the AdQIC Portal. NOTE: CMS contractors should indicate interest in participating as a witness without first making a request for 'leave' with an ALJ.	X	X	X	X					
10641.3.1	Contractors shall note that, in accordance with 42 CFR §405.1020, witness designations/elections shall be made during the coordination of interest/role selection process, as described below, and shall be included in the response to a given Notice of Hearing (NOH).	X	X	X	X					
10641.4	Contractors electing participation status prior to receipt of a formal NOH should note that there is a risk that the case may be later resolved by the ALJ, or an Attorney Adjudicator within the OMHA, without a hearing.	X	X	X	X					
10641.5	Contractors should note that because the AdQIC is tasked with coordinating contractor interest in participation among the related CMS contractors and/or CMS, all NOHs will be sent directly to the AdQIC from the OMHA. The AdQIC, within two (2) calendar days of receipt of the formal NOH from OMHA, will create a record in the AdQIC portal that will generate an email notification to all applicable CMS contractors (e.g., DME	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MAC, A/B MAC, UPIC, SMRC and/or RAC) notifying them that a hearing has been scheduled.									
10641.6	Contractors shall, upon receipt of the formal NOH e-mail alert, log onto the AdQIC website, https://participation.q2a.com , to access the NOH information.	X	X	X	X					
10641.7	Contractors shall make their elections, via the AdQIC website, within five (5) calendar days of the formal NOH e-mail sent date. NOTE: To make an election, contractors shall sign-in on the website (see above), and a dashboard will be available listing all appeals for the respective contractor that they may choose to participate in. Users can also search for appeals based on the information provided in the notification email.	X	X	X	X					
10641.8	Contractors shall select the applicable NOH identifier and complete/submit the CMS Contractor Participation Form indicating for each appeal whether they would like to participate as a party, participant, or witness, and/or if they would like to call a witness if made a party to the hearing. NOTE: CMS contractors that fail to sign-in to the AdQIC system and make their respective participation role selections, in the required timeframe, may be precluded from the prioritization process.	X	X	X	X					
10641.9	Contractors should note that users will not be able to view the actual NOH document on the site. The website/dashboard will allow	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	contractors to view all scheduled hearings for which they received an NOH.									
10641.10	Contractors shall note that for all NOH communications (e.g., NOHs received from OMHA, NOH email alerts) received after standard business hours (e.g., 4:00 p.m., ET) and/or during weekends or business Holidays, as defined by the respective entity, the AdQIC portal is programmed to calculate the response time beginning with the next applicable business day [e.g., if the AdQIC receives the formal NOH on a Friday at 4:00 pm, the five (5) calendar day timeframe begins on Monday (with Monday being day zero (0))].	X	X	X	X					
10641.11	Contractors should note that the AdQIC portal will evaluate all submissions based on CMS' prioritization logic and prioritize contractor roles in a respective ALJ hearing (i.e., which contractor shall be the 'party', 'participants,' etc.), within 2 calendar days of receipt of the completed Contractor Participation forms. NOTE: The website will automatically calculate the contractor's Participation Form response due date and each contractor's role determination, and prioritize participation elections on the next calendar day after the contractor response timeframe expires. Participation/role designations will be sent via a system-generated email notification to any contractors who expressed interest in participation. The status of	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	elections for a given NOH will be available on the AdQIC's website once determinations have been made and notifications have been sent to the applicable CMS contractors.									
10641.12	Contractors should note that within 10 calendar days from the initial NOH receipt date, the AdQIC will reply on behalf of all applicable CMS contractors to the NOH and OMHA with a consolidated response. (The consolidated response shall include a Notice of Election form for each applicable CMS contractor for a given NOH.)	X	X	X	X					
10641.13	Contractors shall, if an amended NOH is issued and they wish to change their method of participation, notify/work with the AdQIC and OMHA, as applicable. NOTE: In the event that OMHA issues an amended NOH, the amended NOH email will be sent from OMHA directly to the AdQIC. The AdQIC will alert all applicable CMS contractors of the amended NOH within 2 calendar days of receipt of the amended NOH email from OMHA. CMS contractor participation roles, as determined via the prioritization process in the response to the original NOH and submitted to OMHA via a Notice of Intent (NOI), shall remain intact following issuance of an amended NOH by OMHA--absent explicit contractor request.	X	X	X	X					
10641.14	Contractors shall be aware that certain ALJ related activities occur outside of the AdQIC	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	portal, to include: <ul style="list-style-type: none"> • Elections prior to receipt of a formal NOH; • Notifying other parties to an appeal of a contractor's intent to participate; • Distributing copies of all submitted position papers, written testimony, and/or evidence to the ALJ and other appropriate parties (including in response to amended NOHs); and • Requests for leave. For such actions, the contractor shall ensure their actions coincide with regulatory instruction.									
10641.15	Contractors wishing to object to the time and/or place of a hearing should do so through written notification to the ALJ, as soon as possible but no later than 5 calendar days prior to the hearing.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
--------------------------------	--

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer Phillips, 410-786-1023 or Jennifer.Phillips@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Version 04/25/2014
Check for Updates

3.9 - Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings

(Rev.:853, Issued: 01-04-19; Effective: 02-05-19; Implementation: 02-05-19)

This section in its entirety applies to MACs. This section applies to Recovery Auditors, CERT, UPICs, and the SMRC, as indicated in their SOWs.

Overview:

Effective March 20, 2017 several changes were made to the regulations that outline the activities related to contractor participation in ALJ hearings. Under the new regulations, CMS contractors are limited to 3 roles in an ALJ hearing: a Participant, a Party, or a Witness (defined in detail below). These changes are outlined in 42 CFR §405.1010 and 42 CFR §405.1012.

A physician overseeing participation shall be a current Contractor Medical Director (CMD), a contractor employed physician or any combination thereof. Nurses and other staff may assist the physician with the tasks described in this section. While the physician is generally the primary individual overseeing and/or taking party or participant status, a contractor may elect to have an attorney or clinician take party or participant status, or another experienced qualified individual if approved by their COR. In either situation, the contractor must be prepared to discuss details related to the facts of each claim under appeal, the relevant coverage policies and payment requirements, including any clarification required on decisions made earlier in the appeals process. For post-pay audit/overpayment cases, the contractor must be prepared to discuss the background on how the provider/supplier was selected for review, results of the sample case adjudications, as well as matters related to the extrapolation methodology and/or processes.

This section establishes expectations related to the contractor's participation and associated coordination activities, although CMS may provide additional guidance and direction as needed. Further rules and procedures related to the ALJ hearing process are contained in 42 CFR §405.1000.

The MAC shall capture and report the ALJ participation and party data in their monthly status report to CMS. Contractors shall record the frequency of their support as a witness in the narrative field of the monthly status reports. Contractors shall ensure that JOAs are sufficient to support the ALJ hearing process and related coordination activities.

Role of the Participant:

In accordance with the revised regulation under 42 CFR Part §405.1010(c) and (d), all contractors' participation as a participant (i.e., non-party) shall be limited to submitting written testimony and/or position papers (except in those instances when non-party participants are able to provide testimony to clarify factual or policy issues in the case—as noted in the scenario below).

The regulations do not prohibit multiple CMS contractors and/or related entities from participating in the ALJ hearing as a participant. However, if no contractor or CMS invokes party status, then the first entity to submit their election to participate as a non-party participant to the ALJ may participate in the oral hearing (limited to clarification of factual or policy issues, as requested by the ALJ). All other entities may participate, but are precluded from the hearing and may only submit written testimony and/or position papers as indicated in 42 CFR §405.1010(d)(1) and (2). If the contractor is able to participate in the hearing, they shall be adequately prepared to respond to questioning by the ALJ regarding all issues related to the claims under appeal. Because participation status does not include the same rights as full party status, the contractor may not call witnesses or cross-examine witnesses of another party, as indicated in 42 CFR §405.1010(c)(1).

(Note: At this time, CMS would not expect contractors to be responsible for clarifying factual or policy issues for cases/claims outside of their jurisdiction.)

Role of the Party:

Contractors shall invoke party status in ALJ hearings in accordance with the regulatory provisions in 42 CFR § 405.1012 and the CMS-prescribed prioritization process, described below, for cases or items/services of interest to CMS. Under 42 CFR §405.1012(d)(1), the first contractor to invoke party status with the ALJ is made the party to the hearing. All other contractors who invoke party status for that particular hearing are made participants and are precluded from the hearing (See Role of the Participant section above).

Note: At this time, CMS would not expect contractors to be responsible for representing cases/claims outside of their jurisdiction.

If the contractor is interested in a particular case, but is precluded from invoking party status based on the CMS-prescribed prioritization of cases or otherwise, the contractor may request 'leave' from the ALJ in accordance with 42 CFR §405.1012(d)(2). *The request for 'leave' process occurs outside of the Administrative Qualified Independent Contractor (AdQIC) portal, described below.* In submitting a request for 'leave' to the ALJ, the contractor is formally requesting that the ALJ grant the contractor the right to be a secondary party to the hearing. Requests for 'leave' to the ALJ shall also include the reason(s) why the contractor believes that their presence as a secondary party in the ALJ Hearing is necessary. The ALJ shall make the determination as to whether the contractor is granted 'leave.' If this is approved, the contractor shall become a secondary party to the hearing. Alternatively, *if denied*, the contractor may participate as a *participant or as a* witness, based on the circumstance. (See Role of Witness section for additional information).

As a party, the contractor is able to orally participate in the hearing and may file position papers, call witnesses, and/or cross-examine witnesses of other parties. The contractor shall submit any position paper or additional evidence requested by the ALJ in accordance with 42 CFR §405.1012(c)(2)(i) and (ii). The contractor shall be adequately prepared to respond to questioning by the ALJ or other parties regarding all issues related to the claims under appeal. As a party to the hearing, contractors are subject to discovery by the other party to the hearing in accordance with 42 CFR §405.1037.

For Notice of Hearings (NOHs) received that include issues deemed significant by CMS or the contractor, the contractor shall, at a minimum:

- Invoke party status in ALJ cases per volume of ALJ cases funded for this activity;
- Participate in any pre-ALJ hearing conference calls, as needed, with other contractors (as facilitated by the appropriate *Qualified Independent Contractor (QIC)*);
- Coordinate with Medical Director(s) or related personnel from other contractors intending to participate as consultants/expert witnesses, as necessary, in accordance with 42 CFR §405.1010(d)(3). In addition, the MAC shall coordinate with other contractors for those hearings in which they do not invoke party status, but decide to participate as a consultant/expert witness; and/or,
- Participate in the hearings as a party via telephone, video teleconferencing, or in-person.

Role of the Witness:

If the ALJ declines the request for contractor 'leave' on a particular hearing, the contractor may be called as a 'witness' by CMS or another CMS contractor that is a party to the hearing. A determination regarding the need for a 'witness' by the participating party shall be determined by the party and communicated to the contractor prior to the hearing. Contractors should, at their discretion, participate as a 'witness' in any case in which another CMS contractor and/or CMS has requested their support in a hearing. Contractors shall notify the requesting party no later than 10 days prior to the scheduled hearing in those instances in which contractors are unable to support the hearing as a 'witness.' As a 'witness,' contractors shall be tasked with

supporting the party to the hearing in responding to policy or factual issues related to a particular case through direct examination and is subject to cross examination by the opposing party.

Note: Contractors who are interested in acting as a witness may indicate their interest via the AdQIC Portal. CMS contractors may indicate interest in participating as a witness without first making a request for 'leave' with an ALJ. Additionally, in accordance with 42 CFR §405.1020, witness designations/elections shall be made during the coordination of interest/role selection process, as described below, and shall be included in the response to a given NOH.

3.9.1 - Election of Status

(Rev.:853, Issued: 01-04-19; Effective: 02-05-19; Implementation: 02-05-19)

The contractor shall establish a process for assessing the *NOHs* received to determine which cases should be selected for participation, as well as the type of participation (participant, party, or witness) to be employed. Factors to be examined should include, but not be limited to: originator of initial denial, policy implications, dollars at issue, program integrity matters, and the extent to which a particular issue is, or has been, a recurring issue at the ALJ level of appeal.

Contractors shall, for those cases in which they were the medical reviewer issuing the denial subject to appeal, have a prioritized ability to invoke party status (in lieu of other appeals support contractors). This process is further described below.

A. Election of Participation Status Prior to Receipt of a Formal NOH

The election to participate as a participant shall be made consistent with 42 CFR §405.1010 and can be done either prior to receipt of a formal NOH or after the receipt of a formal NOH.

The regulations allow CMS contractors to elect to participate as a participant before issuance and/or receipt of the formal NOH. See section of 42 CFR §405.1010(b)(1) for additional information. If the contractor elects to participate before the receipt of the NOH, it shall send written notice of its intent to the assigned ALJ or attorney adjudicator, or the designee of the Chief ALJ, if no contact assigned yet, and to all parties on the reconsideration (per the prescribed OMHA process) within 30 calendar days after notification that a request for hearing had been filed. In accordance with the regulations, a position paper or written testimony must either be submitted within 14 calendar days of an election to participate, if no hearing has been scheduled, or no later than 5 calendar days prior to the hearing, if a hearing is scheduled, unless the ALJ grants additional time to submit the position paper or written testimony. *Contractors should note that there is a risk that the case may be later resolved by the ALJ, or an Attorney Adjudicator within the OMHA, without a hearing.*

B. Election of Participation or Party Status Following Receipt of the Formal NOH

The election to be a participant or a party to a hearing after receipt of the formal NOH shall be made consistent with 42 CFR §405.1010(b) or 42 CFR §405.1012, respectively, and the CMS-prescribed prioritization process, described below. If through the CMS-prescribed *p*rioritization process it is determined that the contractor may act as either the party or a participant to a hearing, elections of participation must be sent by the Contractor within 10 calendar days of receipt of the NOH at the *AdQIC* to all parties listed on the NOH. Submission of a position paper, written testimony, and/or evidence must be submitted no later than five calendar days before the date of the scheduled hearing. Copies of these items must also be sent to those parties listed on the NOH in accordance with 42 CFR §405.1010(c)(3)(ii) and 42 CFR §405.1012(c)(2)(ii).

C. CMS-prescribed Prioritization *Process and AdQIC Portal for* Providing a Response to the Formal NOH

As the AdQIC is tasked with coordinating contractor interest in participation among the related CMS contractors and/or CMS, all NOHs will be sent directly to the AdQIC from the OMHA. The AdQIC, within two (2) calendar days of receipt of the formal NOH from OMHA, will create a record in the AdQIC portal

that will generate an email notification to all applicable CMS contractors (e.g., DME MAC, A/B MAC, UPIC, SMRC, and/or RAC) notifying them that a hearing has been scheduled.

Upon receipt of the formal NOH e-mail alert, all applicable CMS contractors shall log onto the AdQIC website, <https://participation.q2a.com>, to access the NOH information. All applicable CMS contractors shall make their elections, via the AdQIC website, within five (5) calendar days of the formal NOH e-mail sent date. To make an election, contractors must sign-in on the website (see above), and a dashboard will be available listing all appeals for the respective contractor that they may choose to participate in. Users can also search for appeals based on the information provided in the notification email. Next, the contractors shall select the applicable NOH identifier and complete/submit the CMS Contractor Participation Form indicating for each appeal whether they would like to participate as a party, participant, or witness, and/or if they would like to call a witness if made a party to the hearing. CMS contractors that fail to sign-in to the AdQIC system and make their respective participation role selections, in the required timeframe, may be precluded from the prioritization process.

Note: Users will not be able to view the actual NOH document on the site. The web-site/dashboard will allow contractors to view all scheduled hearings for which they received an NOH.

For all NOH communications (e.g., NOHs received from OMHA, NOH email alerts) received after standard business hours (e.g., 4:00 p.m., ET) and/or during weekends or business Holidays, as defined by the respective entity, the AdQIC portal is programmed to calculate the response time beginning with the next applicable business day [e.g., if the AdQIC receives the formal NOH on a Friday at 4:00 pm, the five (5) calendar day timeframe begins on Monday (with Monday being day zero (0))].

The AdQIC *portal* will *evaluate* all *submissions* received and determine which entity shall have the primary opportunity to participate as a ‘party,’ and which entities can participate as ‘participants’ or ‘witnesses’ based on CMS’ prioritization logic.

The anticipated prioritization for the role of party status is as follows:

- 1) Primary opportunity for the ‘party’ role in an ALJ hearing will be granted to the entity that conducted the initial claim denial (e.g., ZPIC/UPIC, RAC, SMRC or medical review unit within the MAC).
- 2) If the entity that issued the initial claim denial does not have interest in participating as a party (due to workload considerations or otherwise) the QIC will have the primary opportunity to participate as a party.
- 3) If no CMS contractors and/or CMS wish to invoke ‘party’ status in a hearing and multiple entities wish to be a participant, the primary participant shall be the entity that conducted the initial claim denial (e.g., ZPIC/UPIC, RAC, SMRC, or medical review unit within the MAC).
- 4) If the entity that identified/conducted the initial claim denial does not wish to be the ‘primary’ participant on the case, the QIC will have the next opportunity to assume this role.

The *AdQIC portal* will review *and prioritize contractor* roles in a respective ALJ hearing (i.e., which contractor shall be the ‘party’, ‘participants,’ etc.), within 2 calendar days of receipt of the *completed* Contractor Participation forms. *The website will automatically calculate the contractor’s Participation Form response due date and each contractor’s role determination, and prioritize participation elections on the next calendar day after the contractor response timeframe expires. Participation/role designations will be sent via a system-generated email notification to any contractors who expressed interest in participation. The status of elections for a given NOH will be available on the AdQIC’s website once determinations have been made and notifications have been sent to the applicable CMS contractors.*

On rare occasion, the QIC may need to facilitate a call with the CMS and the related contractors to determine the roles and/or responsibilities on a particular hearing.

Within 10 calendar days from the initial NOH receipt date, the AdQIC will reply on behalf of all applicable CMS contractors to the NOH and OMHA with a consolidated response. The consolidated response shall include a Notice of Election form for each applicable CMS contractor for a given NOH.

In the event that OMHA issues an amended NOH, the amended NOH email will be sent from OMHA directly to the AdQIC. The AdQIC will alert all applicable CMS contractors of the amended NOH within 2 calendar days of receipt of the amended NOH email from OMHA. CMS contractor participation roles, as determined via the prioritization process in the response to the original NOH and submitted to OMHA via a Notice of Intent (NOI), shall remain intact following issuance of an amended NOH by OMHA. However, if a CMS contractor wishes to change their method of participation following the receipt of an amended NOH, then the CMS contractor shall notify/work with the AdQIC and OMHA, as applicable (e.g., if another CMS contractor was designated as the Party and the QIC was made a non-party Participant, but now the QIC wishes to serve as a Party following the receipt of an amended NOH, then the QIC must request 'leave' with the ALJ and notify the AdQIC if the request for 'leave' is approved).

D. Communications Outside of the Portal/AdQIC Process

While the AdQIC and its prioritization portal provide useful vehicles for assessing information transcribed from the notices of hearing received from OMHA and providing formal response, contractors are reminded of regulatory communications that occur outside of this process.

Contractors are reminded that the AdQIC portal and prioritization process is initiated by receipt of an NOH from OMHA. Therefore, Contractors electing status prior to receipt of an NOH shall follow the regulatory process (outlined in 42 CFR §405.1010) to alert OMHA and other parties that were sent a copy of the notice of reconsideration of their intent to participate, which occurs outside of the portal.

In accordance with section of 42 CFR §405.1010(b)(2) and (3), if a contractor elects to participate in an ALJ hearing, the contractor (not the AdQIC) shall provide written notice of its intent to participate to the parties who were sent a copy of an NOH. Failure to notify the other parties to the appeal, of the intent to participate, may result in the ALJ determining the contractor's election for a given NOH invalid. This requirement remains applicable in the event of an amended NOH, and contractors shall ensure compliance. All pertinent information (e.g. party names, mailing address) will be available in the portal for a given NOH.

Additionally, CMS contractors participating or taking party status shall provide copies of all submitted position papers, written testimony, and/or evidence to the ALJ and other appropriate parties within the time frames as set forth in 42 C.F.R. sections 405.1010, 405.1012, or 423.2010, as applicable. Failure to provide copies of submitted position papers, written testimony, and/or evidence within the required timeframe will result in the submissions not being considered by the respective ALJ. Providing copies of all submitted position papers, written testimony, and/or evidence to the appropriate parties remains applicable in the event an amended NOH is issued and contractors shall ensure compliance.

If a contractor requests 'leave' to the ALJ, or formally requests the ALJ to grant the contractor the right to be a secondary party to the hearing, this process occurs outside of the portal.

The ALJ sets the hearing date, time, and method by video teleconferencing (VTC), telephone, or in-person if VTC is not available or special circumstances exist. A party may object in writing to the time and place of the hearing, as soon as possible before the originally scheduled time *but no later than 5 calendar days prior to the hearing*, and include the reason for the objection along with a proposed alternative date and time. In addition, a party may request an in-person hearing by notifying the ALJ in writing and following the same procedures noted above for an objection to the time/place of the hearing. The ALJ may reschedule if good cause is established per 42 CFR §405.1020(f) or (g).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4202-N]

Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2024

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces the annual adjustment in the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review under the Medicare appeals process. The adjustment to the AIC threshold amounts will be effective for requests for ALJ hearings and judicial review filed on or after January 1, 2024. The calendar year 2024 AIC threshold amounts are \$180 for ALJ hearings and \$1,840 for judicial review.

DATES: This annual adjustment takes effect on January 1, 2024.

FOR FURTHER INFORMATION CONTACT: Liz Hosna, (410) 786-4993.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1869(b)(1)(E) of the Social Security Act (the Act) established the amount in controversy (AIC) threshold amounts for Administrative Law Judge (ALJ) hearings and judicial review at \$100 and \$1,000, respectively, for Medicare Part A and Part B appeals. Additionally, section 1869(b)(1)(E) of the Act provides that beginning in January 2005, the AIC threshold amounts are to be adjusted annually by the percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved and rounded to the nearest multiple of \$10. Sections 1852(g)(5) and 1876(c)(5)(B) of the Act apply the AIC adjustment requirement to Medicare Part C/Medicare Advantage (MA) appeals and certain health maintenance organization and competitive health plan appeals. Health care prepayment plans are also subject to MA appeals rules, including the AIC adjustment requirement, pursuant to 42 CFR 417.840. Section 1860D-4(h)(1) of the Act, provides that a Medicare Part D plan sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) of the Act

with respect to benefits, including appeals and the application of the AIC adjustment requirement to Medicare Part D appeals.

A. Medicare Part A and Part B Appeals

The statutory formula for the annual adjustment to the AIC threshold amounts for ALJ hearings and judicial review of Medicare Part A and Part B appeals, set forth at section 1869(b)(1)(E) of the Act, is included in the applicable implementing regulations, 42 CFR 405.1006(b) and (c). The regulations at § 405.1006(b)(2) require the Secretary of Health and Human Services (the Secretary) to publish changes to the AIC threshold amounts in the **Federal Register**. In order to be entitled to a hearing before an ALJ, a party to a proceeding must meet the AIC requirements at § 405.1006(b). Similarly, a party must meet the AIC requirements at § 405.1006(c) at the time judicial review is requested for the court to have jurisdiction over the appeal (§ 405.1136(a)).

B. Medicare Part C/MA Appeals

Section 1852(g)(5) of the Act applies the AIC adjustment requirement to Medicare Part C appeals. The implementing regulations for Medicare Part C appeals are found at 42 CFR 422, subpart M. Specifically, sections 422.600 and 422.612 discuss the AIC threshold amounts for ALJ hearings and judicial review. Section 422.600 grants any party to the reconsideration (except the MA organization) who is dissatisfied with the reconsideration determination a right to an ALJ hearing as long as the amount remaining in controversy after reconsideration meets the threshold requirement established annually by the Secretary. Section 422.612 states, in part, that any party, including the MA organization, may request judicial review if the AIC meets the threshold requirement established annually by the Secretary.

C. Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

Section 1876(c)(5)(B) of the Act states that the annual adjustment to the AIC dollar amounts set forth in section 1869(b)(1)(E)(iii) of the Act applies to certain beneficiary appeals within the context of health maintenance organizations and competitive medical plans. The applicable implementing regulations for Medicare Part C appeals are set forth in 42 CFR 422, subpart M and apply to these appeals in accordance with 42 CFR 417.600(b). The Medicare Part C appeals rules also apply

to health care prepayment plan appeals in accordance with 42 CFR 417.840.

D. Medicare Part D (Prescription Drug Plan) Appeals

The annually adjusted AIC threshold amounts for ALJ hearings and judicial review that apply to Medicare Parts A, B, and C appeals also apply to Medicare Part D appeals. Section 1860D-4(h)(1) of the Act regarding Part D appeals requires a prescription drug plan sponsor to meet the requirements set forth in sections 1852(g)(4) and (g)(5) of the Act, in a similar manner as MA organizations. The implementing regulations for Medicare Part D appeals can be found at 42 CFR 423, subparts M and U. More specifically, § 423.2006 of the Part D appeals rules discusses the AIC threshold amounts for ALJ hearings and judicial review. Sections 423.2002 and 423.2006 grant a Part D enrollee who is dissatisfied with the independent review entity (IRE) reconsideration determination a right to an ALJ hearing if the amount remaining in controversy after the IRE reconsideration meets the threshold amount established annually by the Secretary, and other requirements set forth in § 423.2002. Sections 423.2006 and 423.2136 allow a Part D enrollee to request judicial review of an ALJ or Medicare Appeals Council decision if the AIC meets the threshold amount established annually by the Secretary, and other requirements are met as set forth in these provisions.

II. Provisions of the Notice—Annual AIC Adjustments

A. AIC Adjustment Formula and AIC Adjustments

Section 1869(b)(1)(E)(iii) of the Act requires that the AIC threshold amounts be adjusted annually, beginning in January 2005, by the percentage increase in the medical care component of the CPI for all urban consumers (U.S. city average) for July 2003 to July of the year preceding the year involved and rounded to the nearest multiple of \$10.

B. Calendar Year 2024

The AIC threshold amount for ALJ hearings will remain at \$180 and the AIC threshold amount for judicial review will decrease from \$1,850 for CY 2023 to \$1,840 for CY 2024. These amounts are based on the 83.702 percent change in the medical care component of the CPI, which was at 297.600 in July 2003 and rose to 546.678 in July 2023. The AIC threshold amount for ALJ hearings changes to \$183.70 based on the 83.702 percent increase over the initial threshold amount of

\$100 established in 2003. In accordance with section 1869(b)(1)(E)(iii) of the Act, the adjusted threshold amounts are rounded to the nearest multiple of \$10. Therefore, the CY 2024 AIC threshold amount for ALJ hearings is \$180.00. The AIC threshold amount for judicial

review changes to \$1,837.02 based on the 83.702 percent increase over the initial threshold amount of \$1,000. This amount was rounded to the nearest multiple of \$10, resulting in the CY 2024 AIC threshold amount of \$1,840.00 for judicial review.

C. Summary Table of Adjustments in the AIC Threshold Amounts

In the following table we list the CYs 2020 through 2024 threshold amounts.

	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
ALJ Hearing	\$170	\$180	\$180	\$180	\$180
Judicial Review	1,670	1,760	1,760	1,850	1,840

III. Collection of Information Requirements

This document announces the annual adjustment in the AIC threshold amounts. It does not impose any "collection of information"

requirements as defined under 5 CFR 1320.3(c). Consequently, the notice is not subject to the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2023-21500 Filed 9-28-23; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS-10718, CMS-10142 and CMS-10540]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (the PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information (including each proposed

extension or reinstatement of an existing collection of information) and to allow 60 days for public comment on the proposed action. Interested persons are invited to send comments regarding our burden estimates or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments must be received by November 28, 2023.

ADDRESSES: When commenting, please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in any one of the following ways:

1. *Electronically.* You may send your comments electronically to <http://www.regulations.gov>. Follow the instructions for "Comment or Submission" or "More Search Options" to find the information collection document(s) that are accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number: _____ Room C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing>.

FOR FURTHER INFORMATION CONTACT: William N. Parham at (410) 786-4669.

SUPPLEMENTARY INFORMATION:

Contents

This notice sets out a summary of the use and burden associated with the following information collections. More detailed information can be found in each collection's supporting statement and associated materials (see **ADDRESSES**).

- CMS-10718 Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form
- CMS-10142 Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)
- CMS-10540 Quality Improvement Strategy Implementation Plan, Progress Report, and Modification Summary Supplement Forms

Under the PRA (44 U.S.C. 3501-3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term "collection of information" is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA requires federal agencies to publish a 60-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice.

Information Collection

1. *Type of Information Collection Request:* Revision with change to the currently approved collection; *Title of Information Collection:* Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form; *Use:* The enrollment form is considered a "model" under Medicare regulations at §§ 422.2262 and 423.2262, for purposes of



Medicare Parts A & B Appeals Process



Table of Contents

What’s Changed?	3
Appointing a Representative.....	6
Transfer Appeal Rights to Non-Participating Providers & Suppliers	6
First Appeal Level: MAC Redetermination.....	7
Second Appeal Level: QIC Reconsideration.....	9
Third Appeal Level: OMHA Decision	11
Fourth Appeal Level: Medicare Appeals Council (Council) Review	14
Fifth Appeal Level: U.S. District Court Judicial Review.....	16
Tips	16
Summary	17
Resources	18

Version 04/25/2024
Check for Updates

What's Changed?

Note: No substantive content updates.

Version 04/25/2024
Check for Updates

This booklet informs health care providers about Medicare's 5 appeal levels in Fee-for-Service (FFS) (Original Medicare) Parts A and B and includes resources on related topics. It also describes how providers, physicians, and suppliers apply the appeals process to their services. It doesn't cover Medicare Parts C or D appeals.

**LEVEL
1****Medicare Administrative Contractor (MAC) Redetermination****LEVEL
2****Qualified Independent Contractor (QIC) Reconsideration****LEVEL
3****Office of Medicare Hearings and Appeals (OMHA) Decision****LEVEL
4****Medicare Appeals Council (Council) Review****LEVEL
5****U.S. District Court Judicial Review**

Make all appeal requests in writing.

In this booklet, **I** or **you** refers to patients, parties, and appellants active in an appeal.

Helpful Terms

Amount in Controversy (AIC): The required level 3 and level 5 appeal dollar amount still in dispute. We annually adjust the AIC by a percentage increase tied to the consumer price index.

Appeal: The process used to request review when a party (for example, a patient, provider, or supplier) disagrees with an initial determination or revised determination on a claim for health care items or services.

Appellant: A person or entity filing an appeal.

Attorney Adjudicator: A licensed attorney with knowledge of Medicare coverage and payment laws who HHS OMHA employs, and who's authorized to review and issue dispositions on certain requests for an Administrative Law Judge (ALJ) hearing or review of a QIC dismissal.

Determination: A decision on coverage and claim payment and liability.

Escalation: When an appellant requests to move a reconsideration pending at the QIC level (second appeal level) or higher to the next level because the adjudicator can't make a prompt decision or dismissal. The appeal must meet the applicable AIC level 3 and level 5 requirements.

Medicare Redetermination Notice (MRN): A MAC letter informing a party about a redetermination decision.

Non-Participating: Physicians and suppliers who haven't signed a Medicare participation agreement but may choose to accept or not accept Medicare assignment on a claim-by-claim basis. Non-participating physicians and suppliers have limited appeal rights.

On-the-Record: A decision based solely on information within the administrative record. No hearing is held.

Party: A person or entity with standing to appeal an initial determination or subsequent administrative appeal determination or decision.

Appointing a Representative

A party may appoint an individual, including an attorney, to represent them at any time during the claim or appeal process.

To appoint a representative, the party and representative must complete the [Appointment of Representative \(CMS-1696\)](#) or any document that:

- Includes a statement appointing the representative to act for the party
 - If the party is the patient, includes a statement authorizing the adjudicator to release identifiable health information to the appointed representative
- Includes a written explanation of the representative's purpose and scope
- Includes the party and representative's names, phone numbers, and addresses
- Includes the representative's professional status or relationship to the party
- Includes the represented party's unique identifier
 - If the party is the patient, includes their MBI
 - If the party is a provider or supplier, includes their NPI
- Is filed with the entity processing the party's initial determination or appeal
- The party and representative sign and date

Note: If providers and suppliers who furnish items or services to a patient that are subject to appeal and wish to represent the patient, they can't charge the patient a fee and must agree to waive the right to collect payment for items or services described in Section 1879(a)(2) of the [Social Security Act](#).

The appointment documentation is valid for 1 year from the date it has the signatures of both the party and appointed representative. You can use the appointment for multiple claims or appeals during that year unless the party specifically withdraws the representative's authority. Once an appointment is filed with an appeal request, the appointment is valid beyond 1 year throughout all appeal levels, unless revoked.

Appointing Representatives

[42 CFR 405.910](#) has the requirements for appointing a representative.

Transfer Appeal Rights to Non-Participating Providers & Suppliers

Patients may transfer their appeal rights to non-participating providers or suppliers who provide the items or services and don't otherwise have appeal rights. To transfer appeal rights, the patient and non-participating provider or supplier must complete and sign the [Transfer of Appeal Rights \(CMS-20031\)](#).

LEVEL 1

First Appeal Level: MAC Redetermination

A redetermination is the first appeal level after the initial claim determination.

Table 1. Redetermination FAQs & Answers

Question	Answer
When must I file a request?	File a redetermination request within 120 days of the date you get the electronic remittance advice (ERA) or standard paper remittance (SPR) advice with the initial determination. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame.
How do I file a request?	File your request in writing by following the ERA or SPR instructions. Use the Medicare Redetermination Request (CMS-20027) or any written document with the required appeal elements shown on the ERA or SPR. Send your request to the address on the ERA or SPR or find your MAC's website for instructions on how to send your request electronically. We consider the request filed on the date the contractor gets it. First Level of Appeal: Redetermination by a Medicare Contractor has more information about what's required for a request. Remember <ul style="list-style-type: none"> • You or your representative must include all required information • Attach any supporting documents • Keep a copy of all appeal documents you send to Medicare
Is there a minimum AIC requirement?	No
Who decides?	MAC staff who weren't involved with the initial claim determination do the redetermination.
How long does it take to decide?	MACs generally issue a decision within 60 days of the date they get a redetermination request. Your MAC will tell you their decision with an MRN, or, if they reverse the initial decision and pay the claim in full, you'll get a revised ERA or SPR.

Table 1. Redetermination FAQs & Answers (cont.)

Question	Answer
<p>Can a MAC dismiss a redetermination request?</p>	<p>A MAC may dismiss a redetermination request:</p> <ul style="list-style-type: none"> • If the appellant party (or appointed representative) requests their appeal be withdrawn • If there are specific defects, like: <ul style="list-style-type: none"> • The party didn't file a request within the appropriate time frame and didn't show (or the MAC didn't decide in favor of) good cause for the late filing • There's no initial determination • The requestor isn't a proper party <p>Medicare Claims Processing Manual, Chapter 29 has MAC dismissal information.</p> <p>Parties to MAC dismissals can dispute the dismissal by:</p> <ul style="list-style-type: none"> • Requesting a QIC review of the MAC dismissal within 60 days of getting the dismissal notice (second appeal level) • Requesting the MAC vacate the dismissal within 180 days of getting the dismissal notice <ul style="list-style-type: none"> • We presume the receipt date is 5 days after the notice date, unless there's evidence you didn't get the determination decision or notice within that time frame

Note: [MLN Matters® Article SE17010](#) explains DME supplier process improvements for filing claims for Medicare FFS recurring (or serial) capped rental items and certain inexpensive and routinely purchased items. These improvements help correct claim errors without initiating the appeal process for all claims in a series.



LEVEL
2

Second Appeal Level: QIC Reconsideration

If you disagree with the MAC’s redetermination decision, you may request a QIC reconsideration. A QIC reconsideration is an independent review of the administrative record, including the initial determination and redetermination.

Table 2. Reconsideration FAQs & Answers

Question	Answer
When must I file a request?	File a reconsideration request within 180 days of the date you get the notice of the redetermination decision. If the MAC dismissed your redetermination request, file your request within 60 days of the date you get the dismissal. We presume the receipt date is 5 days after the notice date unless there’s evidence you didn’t get it within that time frame.
How do I file a request?	<p>File your request in writing by sending it to the address on the MRN, dismissal notice, or remittance advice (RA), or find the QIC’s website for instructions on how to send your request electronically. Use the Medicare Reconsideration Request (CMS-20033) or any written document with the required elements shown on the MRN, dismissal notice, or RA.</p> <p>Second Level of Appeal: Reconsideration by a QIC has more information about what’s required for a request.</p> <p>Remember</p> <ul style="list-style-type: none"> • Clearly explain why you disagree with the redetermination decision • You or your representative must include all required information • Be sure to include the following on your request: <ul style="list-style-type: none"> • RA or MRN copy • Patient’s name and MBI • Missing evidence listed on the redetermination notice and other relevant evidence or documents • Name of the MAC that issued the redetermination <p>If you send documents after you file the reconsideration request, it may extend the QIC’s decision time frame.</p> <p>Make sure you send all evidence you want reviewed with your reconsideration request. If you submit evidence at later appeal levels, it won’t be considered unless you show good cause.</p>

Table 2. Reconsideration FAQs & Answers (cont.)

Question	Answer
Is there a minimum AIC requirement?	No
Who decides?	The QIC does the reconsideration and independently reviews the administrative record, including the redetermination. A panel of physicians or other health care professionals may review medical necessity issues as part of the reconsideration. A QIC review of a MAC dismissal is limited to whether the dismissal was appropriate.
How long does it take to decide?	<p>A QIC generally issues a decision to all parties within 60 days of the date they get a reconsideration request. If the QIC can't complete its decision within that time frame, it informs you of your rights and the procedures to escalate the case to OMHA.</p> <p>If you don't get a reconsideration decision within 60 days, consider allowing an extra 5–10 days for mail delays before escalating your appeal to OMHA. Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals has more information about escalating your appeal to OMHA.</p>
Can a QIC dismiss a reconsideration request?	<p>A QIC may dismiss a reconsideration request:</p> <ul style="list-style-type: none"> • If the appellant party (or appointed representative) requests their appeal be withdrawn • If there are specific defects, like: <ul style="list-style-type: none"> • The party didn't file a request within the appropriate time frame and didn't show (or the QIC didn't decide in favor of) good cause for the late filing • There's no redetermination • The requestor isn't a proper party <p>42 CFR 405.972 has QIC dismissal information.</p> <p>Parties to QIC dismissals can dispute the dismissal by:</p> <ul style="list-style-type: none"> • Requesting an OMHA ALJ dismissal review within 60 days of getting the dismissal notice • Requesting the QIC vacate the dismissal within 180 days of getting the dismissal notice

LEVEL
3

Third Appeal Level: OMHA Decision

If you disagree with the QIC reconsideration decision or dismissal, or you want to escalate your appeal because the reconsideration decision time frame passed, you can request an ALJ hearing or review of a dismissal.

This appeal level allows you—via phone, video-teleconference (VTC), or occasionally in person—to explain your position to an ALJ. If you don’t want to attend a hearing, you can ask an OMHA ALJ or attorney adjudicator to decide based on the evidence in the “administrative record of the appeal” (known as an “on-the-record” decision). The HHS OMHA is the third appeal level and is functionally and organizationally independent from CMS.

Table 3. OMHA Review FAQs & Answers

Question	Answer
When must I file a request?	File an ALJ hearing request within 60 days of the date you get the reconsideration decision letter or QIC dismissal notice. If you’d like an escalation to OMHA, file a request with the QIC for OMHA review after the reconsideration period expires. We presume the receipt date is 5 days after the notice date unless there’s evidence you didn’t get it within that time frame.
How do I file a request?	<p>File your request in writing by following the instructions included with the reconsideration letter or QIC dismissal notice. The OMHA e-Appeal Portal allows you to electronically submit Medicare Part A and B appeal requests, upload documentation, and get appeal status information.</p> <p>If you don’t want a phone hearing, you may ask for an in-person or VTC hearing. Unless you’re an unrepresented Medicare patient requesting a VTC hearing, you must demonstrate good cause for a VTC or in-person hearing. The ALJ sets hearing procedures, including the time and place.</p> <p>If you prefer to waive a hearing, select that choice in OMHA-100, Section 9, and complete a Waiver of Right to an ALJ Hearing (OMHA-104). If you already sent your OMHA-100 form, complete a Waiver of Right to an ALJ Hearing (OMHA-104) and send it to the assigned OMHA adjudicator.</p> <p>If OMHA grants an on-the-record review, an OMHA adjudicator issues a decision based on information in the administrative record and any evidence sent with the request, subject to new evidence standards.</p> <p>Office of Medicare Hearings and Appeals and Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals has more information about requesting an ALJ hearing and the requirements, including forms.</p>

Table 3. OMHA Review FAQs & Answers (cont.)

Question	Answer
How do I file a request?	<p>Remember</p> <ul style="list-style-type: none"> Send a copy of the ALJ hearing request to all other QIC reconsideration parties. If you request a Council escalation, send a copy to all other parties and the assigned adjudicator or OMHA Central Operations (if the adjudicator isn't assigned). CMS or its contractors may become a party to, or participate in, an ALJ hearing after notifying the ALJ and all involved parties.
Is there a minimum AIC requirement?	<p>Yes. A party to a QIC reconsideration has a right to a hearing before an ALJ only if the amount remaining in controversy meets or exceeds the applicable, annually updated AIC threshold.</p> <p>OMHA FAQs has information about how the AIC is calculated.</p> <p>42 CFR 405.1006(e)(1)–(f)(2) has more information on aggregating claims to meet the AIC requirement and aggregating claims escalated from the QIC level for an ALJ hearing.</p>
Who decides?	<p>The ALJ or attorney adjudicator decides and issues a decision. Review of a QIC dismissal is limited to whether the dismissal was appropriate.</p> <p>If an ALJ or attorney adjudicator doesn't issue a decision within the applicable time frame, you may escalate the appeal to the Council. Otherwise, the appeal remains pending with OMHA.</p> <p>Once the ALJ or attorney adjudicator completes case actions, OMHA sends the disposition package and case file to the Administrative QIC (AdQIC) (the central manager for all Medicare FFS claim case files appealed to QIC or beyond). In certain situations, the AdQIC may refer the case to the Council on our behalf.</p> <p>If no referral is made to the Council and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC tells the MAC it must process the claim, according to the OMHA disposition, within 30–60 days of the MAC's receipt of the AdQIC notification.</p>

Table 3. OMHA Review FAQs & Answers (cont.)

Question	Answer
<p>How long does it take to decide?</p>	<p>For Part A and B appeals, OMHA has 90 days to complete its review and issue a decision. Although the large appeal request volume previously caused processing delays, OMHA has returned to a 90-day adjudication period.</p> <p>OMHA generally processes ALJ hearing requests in the order they arrive and as quickly as possible, given pending requests and adjudicatory resources.</p> <p>If OMHA doesn't issue a decision within the applicable time frame, you may ask OMHA to escalate the case to the Council. Escalation Rights has information on escalating to the Council.</p> <p>Office of Medicare Hearings and Appeals and ALJ Appeal Status Information System (AASIS) has more information.</p>
<p>Can OMHA dismiss a review request?</p>	<p>OMHA may dismiss an ALJ hearing or QIC dismissal review request:</p> <ul style="list-style-type: none"> • If the appellant party (or appointed representative) requests their appeal be withdrawn • For cause authorized under the regulations <p>42 CFR 405.1052 has more dismissal information.</p> <p>OMHA sends a written dismissal notice to all parties who got a copy of the request for hearing or review.</p> <p>Parties to the OMHA dismissal can dispute the dismissal by:</p> <ul style="list-style-type: none"> • Requesting the adjudicator vacate the dismissal • Requesting the Medicare Appeals Council (the Council) review the dismissal within 60 days after they get the dismissal notice



LEVEL 4

Fourth Appeal Level: Medicare Appeals Council (Council) Review

If you disagree with the ALJ or attorney adjudicator decision or dismissal, or you want to escalate your appeal because the OMHA adjudication time frame passed, you may request a Council review. The Council is part of the HHS Departmental Appeals Board (DAB).

Table 4. Council Review FAQs & Answers

Question	Answer
When must I file a request?	File a Council review request within 60 days of the date you get the OMHA decision or dismissal. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame
How do I file a request?	<p>You may use 1 of these methods to file a request for review:</p> <ul style="list-style-type: none"> • File your request in writing by following the OMHA decision or dismissal instructions • Complete a Request for Review of ALJ Medicare Decision/Dismissal (DAB-101) and mail, fax, or email it following the instructions on the form • File a request electronically for review through DAB E-File DAB Medicare Operations Division (MOD) E-File if you're a registered user <p>Medicare Appeals Council and Fourth Level of Appeal: Review by the Medicare Appeals Council has more information about requesting a Council review and requirements after an OMHA decision.</p> <p>Remember</p> <ul style="list-style-type: none"> • Specify which part of the OMHA decision or dismissal you disagree with and why you think the ALJ or attorney adjudicator was wrong • Send a copy of the request for review to all parties that were copied on the OMHA decision or dismissal
Is there a minimum AIC requirement?	No

Table 4. Council Review FAQs & Answers (cont.)

Question	Answer
Who decides?	<p>The Council. The Council may adopt, modify, reverse, or remand the ALJ’s or attorney adjudicator’s decision. The Council may also dismiss the review request, deny review, or remand the ALJ’s or attorney adjudicator’s dismissal, or dismiss the ALJ hearing request. Review of an OMHA dismissal is limited to whether the dismissal was appropriate.</p> <p>The Council sends the decision and case file to the AdQIC, the central manager for all Council FFS Medicare claim case files.</p> <p>If the Council overturns a previous denial (in whole or in part), the AdQIC directs the MAC to pay the claim, according to the Council’s decision.</p>
How long does it take to decide?	<p>Generally, the Council is expected to adjudicate Part A and Part B appeals within 90 days. However, case processing delays, including claim file defects, at the lower levels of the appeals process may impact adjudication at the Council level.</p> <p>If the Council review comes from an escalated appeal, the Council has 180 days from the date they get the escalation request to issue a decision. However, various factors may prevent the Council from issuing a decision or order within the regulatory time frame.</p> <p>If the Council doesn’t issue a decision within the applicable time frame, you may ask the Council to escalate the case to the U.S. District Court.</p> <p>If you request U.S. District Court escalation, you must send a copy of the request to all other parties and the Council.</p>
Can the Council dismiss or deny a review request?	<p>The Council may dismiss a review request:</p> <ul style="list-style-type: none"> • If the appeal request isn’t filed on time • If the party requests to withdraw the review request • If the party doesn’t have a right to request Council review <p>42 CFR 405.1114 has more dismissal information.</p> <p>The Council may deny a review request of an ALJ’s or attorney adjudicator’s dismissal if the appeal request is valid and the Council finds that the ALJ or attorney adjudicator didn’t error in dismissing the appellant’s request for an ALJ hearing.</p> <p>The Council sends a written notice to all parties who were sent a copy of the ALJ’s or attorney adjudicator’s notice of decision. Dismissing a request for Council review of an OMHA dismissal is binding and isn’t subject to further review unless the Council reopens and vacates it. The Council’s notice will inform you of your rights to seek judicial review.</p>

**LEVEL
5**

Fifth Appeal Level: U.S. District Court Judicial Review

If you disagree with the Council decision, or you want to escalate your appeal because the Council decision time frame passed, you may request judicial review.

Table 5. U.S. District Court Judicial Review FAQs & Answers

Question	Answer
When must I file a request?	File a judicial review request within 60 days of the date you got the Council decision or after the Council decision time frame expires.
How do I file a request?	The Council's decision (or notice of escalation right) informs you how to file a claim in U.S. District Court. Fifth Level of Appeal: Judicial Review in Federal District Court has more information about requesting a judicial review.
Is there a minimum AIC requirement?	Yes. A party to a Council decision has a right to a judicial review only if the amount remaining in controversy meets or exceeds the applicable, annually updated AIC threshold .
Who decides?	The U.S. District Court.

Tips

- Make all appeal requests in writing
- File requests on time with the appropriate entity
- Include a copy of the decision letters or claim information issued at prior levels
- Include a copy of the demand letters if appealing an overpayment determination
- If the appeal involves an overpayment determined through sampling and extrapolation, identify all contested sample claims in 1 appeal request and clearly state any sampling methodology challenges
- Include all relevant supporting documents with your first appeal request
- Include a copy of the [Appointment of Representative](#) form if the requestor isn't a party and is representing the appellant
- Respond promptly to document requests

The [Medicare Overpayments](#) fact sheet has more information about the overpayment collection process.

Summary

Table 6. Appeals Process Summary

Level	Review Process Summary	Who Decides?	When Must I File a Request?	How Long Does it Take to Decide?	AIC	Forms
First Level: Medicare Administrative Contractor (MAC) Redetermination	Document the initial claim review determination	MAC	Up to 120 days after you get an initial determination	60 days	No	CMS-20027 CMS-20031
Second Level: Qualified Independent Contractor (QIC) Reconsideration	Document the redetermination review; send any missing appeal evidence	QIC	Up to 180 days after you get the Medicare Redetermination Notice (MRN)	60 days	No	CMS-20033
Third Level: Office of Medicare Hearings and Appeals (OMHA) Decision	May be an interactive hearing between parties or an on-the-record review	Administrative Law Judge (ALJ) or attorney adjudicator	Up to 60 days after you get the QIC decision notice or after the QIC reconsideration expiration time frame if you don't get a decision	90 days if appealing a QIC reconsideration decision or dismissal or 180 days if the appeal was escalated to OMHA	Yes	OMHA-100 OMHA-100A OMHA-104
Fourth Level: Medicare Appeals Council (Council) Review	Document the ALJ's review decision (you may request oral arguments)	Council	Up to 60 days after you get the OMHA's decision notice or after the time frame expiration if you don't get a decision	90 days if appealing an OMHA decision or dismissal or 180 days if the ALJ review time expired without an ALJ decision	No	DAB-101
Fifth Level: U.S. District Court Judicial Review	Judicial review	U.S. District Court	Up to 60 days after you get the Council decision notice or after the Council time frame expiration if you don't get a decision	No statutory time limit	Yes	No HHS form available



Resources

- [42 CFR Part 405, Subpart I](#)
- [Filing an appeal if I have Original Medicare](#)
- [Original Medicare \(Fee-for-service\) Appeals](#)
- [Original Medicare \(Parts A & B\) Appeals Flowchart](#)
- [Section 1869 of the Social Security Act](#)
- [The Appeals Process](#)
- [U.S. Federal Courts](#)

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Version 04/25/2024
Check for Updates