CHAPTER 7

INQUIRIES, OVERPAYMENTS, AND APPEALS

This chapter discusses inquiries, overpayments, and appeals.

Inquiries

Medicare providers and suppliers may submit inquiries about claims, coverage, and reimbursement guidelines to Medicare Contractors either by telephone or in writing. Customer Service Representatives (CSR) are available to handle telephone inquiries continuously during normal business hours for all time zones of the geographic area serviced, Monday through Friday. To find Medicare Contractor contact information, visit *www.cms.hhs.gov/apps/contacts* on the Centers for Medicare & Medicaid Services (CMS) website.

Contractors also use automated self-help tools such as Interactive Voice Response (IVR) services, which may be available up to 24 hours a day. IVR services provide information about the following topics:

- Normal business hours;
- CSR service hours of operation;
- General Medicare Program;
- General appeal rights and the actions required to exercise appeal rights;
- Claims in process and claims completed; and
- Definitions of the 100 most frequently used Remittance Advice Remark Codes and/or Claim Adjustment Reason Codes, which appear on the Remittance Advice (RA) (as determined by each Contractor).

Overpayments

Overpayments are funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of an overpayment has been made, the amount of the overpayment becomes a debt owed to the Federal government. Federal law requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused.

Overpayments are often paid due to the following:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services; or
- Payment made as the primary insurer when Medicare should have paid as the secondary insurer.

If Medicare pays more than the correct amount in error, providers and suppliers should make voluntary refunds as soon as possible, without waiting for notification. A notification called a demand letter is sent when an overpayment occurs, which states:

- The service(s) at issue;
- Why the overpayment occurred; and
- The amount being requested.

Refunds are sent to the Medicare Contractor and must include the following information:

- The Provider Identification Number (PIN) and the PIN of the provider who should actually be paid, if applicable;
- The Medicare Health Insurance Claim (HIC) number;
- The date of service;
- The amount overpaid;
- A brief description regarding the reason for the refund;
- A copy of the RA; and
- A check for the overpaid amount.

If the overpayment is not paid in full within 30 days of the date of the first demand letter, interest begins to accrue on day 31. When the Federal government accepts a voluntary refund, it does not affect or limit its right or the right of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies that arise from or related to applicable claims.

If a provider or supplier disagrees with the overpayment, he or she has the right to appeal the decision. Recoupment will cease if:

- The first recoupment action occurred after December 8, 2003; or
- A first level appeal has been received.

To find additional information about overpayments, see the Medicare Claims Processing Manual (Pub. 100-04) located at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.

Fee-for-Service Appeals

An appeal is an independent review of an initial determination made by a Medicare Contractor. Generally, a party to the initial determination is entitled to an appeal if he or she is dissatisfied with the determination and files a timely appeal request that contains the necessary information needed to process the request.

A party to an initial determination may be:

- A beneficiary who files a request for payment or has a request for payment filed on his or her behalf by a provider;
- A supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the request for payment; or
- A provider of services who files a request for payment for items or services furnished to a beneficiary.

A party to a higher level appeal may be:

- The parties to an initial determination, except when a beneficiary has assigned his or her appeal rights;
- A State agency pursuant to the *Code of Federal Regulations (CFR)* at 42 CFR 405.908 (to access the *CFR*, visit *www.gpoaccess.gov/cfr/index.html* on the Web);
- A provider or supplier who accepts assignment of appeal rights for items or services furnished to a beneficiary; or
- A nonparticipating physician or supplier who does not accept assignment for items or services furnished to a beneficiary and may be obligated to make a refund pursuant to §§1834(a)(18), 1834(j)(4), or 1842(l) of the Social Security Act.

A provider or supplier who is not already a party to an appeal may appeal an initial determination for services furnished to a beneficiary if the beneficiary subsequently dies leaving no other party available to appeal the determination.

A party may appoint a representative if he or she wants assistance with their appeal. A physician or supplier may act as a beneficiary's appointed representative. A party may appoint a representative to act on his or her behalf by completing Form CMS-1696, Appointment of Representative (AOR), which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website. A party may also appoint a representative through a submission that meets the following requirements:

- It is in writing and is signed and dated by both the party and the individual who is agreeing to be the representative;
- It includes a statement appointing the representative to act on behalf of the party and if the party is a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative;
- It includes a written explanation of the purpose and scope of the representation;
- It contains the name, telephone number, and address of both the party and the appointed representative;
- If the party is a beneficiary, the beneficiary's Medicare HIC number;

- It indicates the appointed representative's professional status or relationship to the party; and
- It is filed with the entity that is processing the party's initial determination or appeal.

A representative may submit arguments, evidence, or other materials on behalf of the party. The representative, the party, or both may participate in all levels of the appeals process. Once both the party and the representative have signed the AOR Form, the appointment is valid for one year from the date of the last signature for the purpose of filing future appeals unless it has been revoked.

As noted above, a beneficiary may also assign (transfer) his or her appeal rights to a physician or supplier who is not a party to the initial determination and who furnished the items or services at issue in the appeal. A beneficiary must assign appeal rights using the form CMS-20031, Transfer of Appeal Rights, available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website. A physician or supplier who accepts assignment of appeal rights must waive the right to collect payment from the beneficiary for the items or services at issue in the appeal, with the exception of deductible and coinsurance amounts and when a valid Advance Beneficiary Notice is in effect.

After an initial claim determination is made, the appeals process is as follows:

- Redetermination by Medicare Contractor;
- Reconsideration by Qualified Independent Contractor (QIC);
- Hearing by Administrative Law Judge (ALJ);
- De Novo Review by Medicare Appeals Council (MAC); and
- Judicial Review.

First Level of Appeal – Redetermination by Medicare Contractor

A party who is dissatisfied with the initial determination may request that a Medicare Contractor conduct a redetermination. The redetermination, which is an independent review of the initial determination, is conducted by an employee of the Contractor who was not involved in making the initial determination. A request for a redetermination must be filed within 120 calendar days of the date the notice of initial claim determination is received. If good cause is shown, the period for filing the appeal request may be extended. At this level of appeal, there is no amount in controversy (AIC) requirement. When filing the request for redetermination, parties should also submit all relevant documentation to support their assertion that the initial claim determination was incorrect.

Parties must request redeterminations in writing by either completing Form CMS-20027, Medicare Redetermination Request, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service; and
- Name and signature of the party or representative of the party.

In most cases, the Contractor will issue a written redetermination notice to all parties to the appeal within 60 days of receipt of the redetermination request. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA.

Second Level of Appeal – Reconsideration by QIC

A party dissatisfied with the redetermination decision may request a reconsideration by a QIC. For all redeterminations issued on or after January 1, 2006, the reconsideration by the QIC replaces the Hearing Officer Hearing previously conducted by Medicare Part B Contractors. Appeals of redeterminations issued prior to January 1, 2006 will be conducted by hearing officers.

A party must file a written request for a reconsideration with the entity specified in the redetermination notice within 180 calendar days of the date the redetermination decision is received. If good cause is shown, the QIC may extend the period for filing the request. At this level of appeal, there is no AIC requirement. A party may file a written request for reconsideration by either completing Form CMS-20033, Medicare Reconsideration Request, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service;
- Name and signature of the party or representative of the party; and
- Name of the Contractor that made the redetermination.

For appeals of redeterminations issued prior to January 1, 2006, parties may file a written request for a Hearing Officer Hearing by either completing Form CMS-1965, Request for Hearing, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS

website or by submitting a written request that includes the information described above. Hearing officers generally issue decision letters within 120 days of receipt of the hearing request.

In most cases, the QIC will issue written notice of its reconsideration decision to all parties within 60 calendar days of receipt of the request for reconsideration. In some situations (e.g., submission of additional evidence after the reconsideration request is filed), the time limit will be extended beyond 60 days. If the QIC is unable to issue a reconsideration within the applicable time limit, the QIC will notify the appellant (the party who filed the appeal request). The appellant may then file a written request with the QIC to escalate the appeal to the Administrative Law Judge (ALJ) level. Within five days of receiving the request to escalate, the QIC will either issue a reconsideration or acknowledge the escalation request and forward the request and case file to the appropriate ALJ office. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. All evidence requested by the Contractor in the redetermination decision must be submitted at the QIC reconsideration level of appeal. Failure to submit requested information at the QIC reconsideration level may lead to exclusion of such evidence at subsequent levels of appeal.

Third Level of Appeal – Hearing by ALJ

If a party is dissatisfied with the reconsideration decision (or Part B hearing officer decision) or if the adjudication period for the QIC to complete its consideration has elapsed, he or she can request a hearing before an ALJ with the Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals. There is an AIC requirement, which will be adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI). The ALJ hearing may be conducted in person, via video teleconferencing (VTC) technology, or by telephone. The ALJ may also issue a decision on the record without the appearance of any parties if the decision is fully favorable to the appellant. In person hearings may be granted upon a finding of good cause. An ALJ may also determine that an in person hearing should be conducted if VTC technology is unavailable or special or unusual circumstances exist.

A party must file a written request for an ALJ hearing with the entity specified in the QIC reconsideration notice (or Part B hearing officer decision letter) within 60 calendar days of receipt of the QIC reconsideration notice or Part B hearing officer decision letter. If a request for an ALJ hearing is not filed timely, the period for filing the request may be extended by the ALJ if good cause is shown.

During the transition from Part B hearing officer decisions to QIC reconsiderations, there will be two different forms that may be used to request an ALJ hearing. If a party is filing a request for an ALJ hearing to appeal a QIC reconsideration, he or she may either complete Form CMS-20034A/B, Request For Medicare Hearing By An Administrative Law Judge, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or submit a written request that includes the following information:

- Name, address, and Medicare HIC number of the beneficiary whose claim is being appealed;
- Name and address of the appellant, when the appellant is not the beneficiary;
- Name and address of any designated representatives;
- Document control number assigned to the appeal by the QIC, if any;
- Dates of service for the items or services at issue;
- Reasons the appellant disagrees with the QIC's reconsideration (or Part B hearing officer decision); and
- Statement of any additional evidence to be submitted and the date it will be submitted.

If a party is filing a request for an ALJ hearing to appeal a hearing officer decision, he or she may either complete Form CMS-5011A/B, Request For Medicare Hearing By An Administrative Law Judge, which is available at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage* on the CMS website or submit a written request that includes the information noted in the paragraph above regarding how to request an ALJ hearing to appeal a QIC reconsideration.

When an appellant requests an ALJ hearing following a QIC reconsideration, the appellant must also send a copy of the request for hearing to the other parties to the appeal. The ALJ's 90-day timeframe to issue a decision does not start until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.

Generally, at the ALJ level, CMS and/or CMS Contractors may elect to either participate in the hearing or become a party to the hearing. If CMS and/or CMS Contractors choose to participate or become a party to the hearing, it will notify the ALJ and all parties within 10 days after receiving the notice of hearing. Participating in the hearing or as a party may include submitting position papers or providing testimony to clarify factual or policy issues, but does not include calling or cross-examining witnesses or being called as a witness. In addition, discovery is allowed only when CMS becomes a party to an ALJ hearing.

In most cases, the ALJ will issue a decision within 90 days of receipt of the request for hearing. The time limit may be extended (for example, if a party issues a discovery request in cases where CMS is a party). If the case before the ALJ was escalated from the QIC, the ALJ must issue a decision in 180 days (unless the time limit was extended for the reasons noted above). If the decision results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. If an ALJ case is still pending at the close of the applicable adjudication timeframe, the appellant may file a written request with the ALJ and the MAC to escalate the appeal to the MAC. The appellant must notify all parties to the ALJ hearing about the escalation request. Failure to send notice to all parties will toll or stop the adjudication timeframes for the MAC to conduct its review.

Fourth Level of Appeal – De Novo Review by MAC

The appellant or any other party to the ALJ hearing may request MAC review of the ALJ's decision or dismissal. The request for MAC review must be filed within 60 calendar days of receipt of the ALJ hearing decision or dismissal. If good cause is shown, the period for filing the request may be extended. At this level of appeal, there is no AIC requirement.

The party must file a written request for MAC review by either completing Form DAB-101, Request for Review of Administrative Law Judge Medicare Decision/Dismissal, which is available at *www.hhs.gov/dab/DAB101.pdf* on the HHS website or submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Specific items or services for which review is requested;
- Dates of service for the items or services at issue;
- Date of the ALJ's final action (if any) or the hearing office in which the party's request for hearing is pending; and
- Name and signature of the party or representative of the party.

The request for MAC review must also identify the parts of the ALJ action with which the party requesting review disagrees and explain why he or she disagrees with the ALJ's decision, dismissal, or other determination being appealed. The MAC will generally limit its review to the issues raised by the appellant and will conduct a *de novo* or new review of such issues.

The appellant must also send a copy of the request for review to the other parties to the ALJ decision or dismissal. The time limit for issuance of the MAC decision (discussed below) does not commence until all parties are properly notified.

Generally, the party requesting the MAC review does not have a right to a hearing before the MAC. The MAC will consider all of the evidence in the administrative record and either adopt, modify, or reverse the ALJ decision or remand the case to the ALJ for further proceedings. However, depending on how the appeal came before the MAC, there may be opportunities for parties to submit additional evidence. Parties to MAC review may request the opportunity to file briefs or other written statements discussing the facts and laws relevant to the case. A party may also request to appear before the MAC to present oral argument. The MAC may also dismiss a review request if the party making the request asks to withdraw the request for MAC review, does not have a right to request MAC review, or in certain circumstances where the beneficiary whose claim is being appealed dies.

In most cases, the MAC decision, dismissal, or remand order will be mailed within 90 calendar days of submission of the request. If the decision results in the issuance of a supplemental payment to a provider or supplier, the Medicare Contractor must also issue an electronic or paper RA. If the case was escalated to the MAC because the ALJ could not issue a timely decision, the MAC will have 180 days to mail its decision. These timeframes may be extended under certain circumstances (for example, if a party filing a request for review fails to provide copies of the request for review to other parties to the ALJ decision or dismissal). If the MAC fails to issue a decision, dismissal, or remand order within the applicable time period, the appellant may submit a request for escalation to Federal District Court. The MAC will either complete the case within five days of receipt of the escalation request or within five days following the end of the applicable adjudication timeframe. If the MAC is unable to complete the case, it will issue a notice to the appellant that acknowledges the escalation request and confirms its inability to issue a decision, dismissal, or remand order within the applicable timeframe. A party may then file a civil action in Federal District Court within 60 days after the date it receives notice from the MAC. In certain instances, if good cause is shows, the period for filing the request may be extended. Escalation is not available with regard to a request to review an ALJ dismissal.

Fifth Level of Appeal – Judicial Review

A party to a MAC decision or an appellant who requests an escalation of a MAC review may obtain judicial review if the case meets the AIC requirement. For actions filed on or after January 1, 2006, the AIC will be $1,090. The AIC amount is adjusted annually in accordance with the percentage increase in the medical care component of the CPI.

Any civil action for judicial review must be filed in the District Court of the U.S. for the judicial district in which the party resides or where such individual, institution, or agency has its principal place of business. If the party does not reside within

any judicial district or if the individual, institution, or agency does not have its principal place of business within any such judicial district, the civil action must be filed in the District Court of the U.S. for the District of Columbia. The Secretary of HHS is the proper defendant in any request for judicial review of a MAC decision or a case escalated to Federal District Court.

Complaints filed in Federal District Court against the Secretary of HHS should also be sent to:

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

The District Court may either reach a final decision or remand the case to the MAC or ALJ for further proceedings. Written notification regarding the District Court's decision is sent to all the parties.

Liability and Appeal Decisions

Liability regarding appeal decisions is as follows:

- When an original claim determination for both assigned and nonassigned claims is upheld on a review and the provider or supplier knew or could have been expected to know that payment for the service might be denied or reduced, he or she is held liable and must refund any monies collected from the beneficiary within 30 days of the review decision.
- When an original claim determination for an assigned claim is upheld on a review and the provider or supplier and beneficiary could not have been expected to know that payment for the service might be denied or reduced, payment is made to the provider or supplier.
- When an original claim determination for a nonassigned claim is upheld on a review and it is found that the provider or supplier could not have been expected to know that payment for the service might be denied or reduced, he or she is notified that payment may be collected from the beneficiary. A letter is sent to the beneficiary indicating that he or she is responsible for payment.

- When the beneficiary is not responsible for the payment of a service, the provider or supplier must refund any monies collected from the beneficiary. If the refund is not made within the specified time limits, the following actions may occur:
    - For an assigned claim, the beneficiary may submit a request to Medicare for indemnification from payment. A letter is sent to the provider or supplier indicating that a refund must be made to the beneficiary within 15 days for the amount actually paid, including any amounts applied to deductibles, coinsurance, and copayments. If the refund is not made within 15 days, Medicare will pay the beneficiary and request a refund from the provider or supplier.
    - For a nonassigned claim, the beneficiary may notify Medicare that the provider or supplier did not refund the amount due. A letter is sent to the provider or supplier indicating that a refund is due to the beneficiary within 15 days. If a refund is not made within 15 days, the provider or supplier may be subject to Civil Monetary Penalties and sanctions.

Reopening

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening allows the correction of minor errors or omissions without initiating a formal appeal. If a claim is denied because a Contractor did not receive requested documentation during medical review and the party later requests a redetermination, the Contractor must process the request as a reopening. A Contractor must also process clerical errors (including human and mechanical errors on the part of the party or Contractor) such as mathematical or computational mistakes, inaccurate data entry, or denials of claims as duplicates. A reopening is, in general, not conducted until a party's appeal rights have been exhausted. A Contractor, QIC, ALJ, or MAC's decision on whether to reopen is final and not subject to appeal. A reopening may be requested by a party or initiated by a Contractor, QIC, ALJ, or MAC.

The timeframes and requirements for requesting or initiating a reopening will depend on the level at which the reopening is requested (initial determination level or one of the appeals levels) and who is initiating the reopening (a party, Contractor, QIC, ALJ, or MAC). When any determination or decision is reopened and revised, a Contractor, QIC, ALJ, or MAC must mail its revised determination or decision to the parties. If the reopening action results in an adverse revised determination or decision, the Contractor shall mail a letter that states the rationale for the reopening, the applicable revision, and any right to appeal.

To find additional information about appeals, see the Medicare Claims Processing Manual (Pub. 10-4) at *www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage* on the CMS website.