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Module 9

STUDY GUIDE

PREPARE FOR SUCCESS

Home Health Medical Billing Certificate

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Credit balance report

General

The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses the information. In accordance with sections 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, all providers participating in the Medicare program are to complete a Medicare Credit Balance Report (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit." However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period; e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Only Medicare credit balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the manual [each provider manual will have the appropriate cite for that manual] that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

Submitting the CMS-838

Submit a completed CMS-838 to your fiscal intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including

transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

Completing the CMS-838

The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. This page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you have reported. An electronic file (or hard copy) of the detail page is available from your FI.

You may submit the detail page(s) on a diskette furnished by your contractor or by a secure electronic transmission as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

NOTE: Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;
- The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;
- The month, day and year of the reporting quarter; e.g., 12/31/02;
- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;
- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and
- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Payment of Amounts Owed Medicare

Providers must pay all amounts owed (column 9 of the report) at the time the credit balance report is submitted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a separate adjustment bill, electronic or hard copy, for all individual credit balances that pertain to open cost reporting periods. The FI will ensure that the monies are not collected twice.
- Submission of the detail information on the CMS-838 will not be accepted by the FI as an adjustment bill.
- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).
- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that "if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare…" the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due.

If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.

- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, you may contact your FI regarding an extended repayment schedule.

Records Supporting CMS-838 Data

Develop and maintain documentation that shows that each patient record with a credit balance (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the CMS-838.

At a minimum, your procedures should:

- Identify whether the patient is an eligible Medicare beneficiary;
- Identify other liable insurers and the primary payer;
- Adhere to applicable Medicare payment rules; and
- Ensure that the credit balance is due and refundable to Medicare.

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes. Provider Based Home Health Agencies (HHAs) Provider-based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it

may be different from the FI servicing the parent facility. Exception for Low Utilization Providers Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, section 2414.4.B, or files less than 25 Medicare claims per year. Compliance with MSP Regulations MSP regulations at 42 CFR 489.20(h) require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of the CMS-838 and adherence to CMS' instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period. Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it on the CMS-838; i.e., once payment is made, a credit balance would no longer be reflected in your records. If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.

Medicare Provider Cost Report Public Use Files

The Cost Report Public Use Files present select measures provided by Medicare providers through their annual cost report, and are organized at the provider level. Most Medicare-certified providers are required to submit an annual cost report to CMS. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). For more information about the HCRIS, and a complete list of variables included in the cost reports, please see https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/.

Payment: RAs, EFTs, PC Print

The Remittance Advice (RA) is a notice of payment sent as a companion to claim payments by Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to providers, physicians, and suppliers.

WHAT IS AN RA?

When you submit a claim to a MAC, you will receive an RA that explains the payment and any adjustment(s) made to a payment during Medicare's adjudication of claims. RAs provide itemized claims processing decision information regarding:

- Payments
- Deductibles and co-pays
- Adjustments • Denials
- Missing or incorrect data

- Refunds
- Claims withholding due to Medicare Secondary Payer (MSP) or penalty situations

The RA provides justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes in the RA will help you identify any additional action you may need to take. For example, some RA codes may indicate that you need to resubmit the claim with corrected information, while others may indicate that you can appeal a payment decision.

For more information about RAs visit https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html.

WHAT TYPES OF RAS ARE AVAILABLE?

MACs send RAs in either an electronic format (Electronic Remittance Advice [ERA]), or a paper format (Standard Paper Remittance Advice [SPR]). Although the information that the two formats provide is similar, the ERA offers some data and administrative efficiencies not available in an SPR. For example, ERAs can be manipulated electronically into a variety of report formats. Further advantages of the ERA are listed later in this booklet. To obtain ERAs, or to switch from receiving SPRs to ERAs, you need to contact your MAC to establish Electronic Data Interchange (EDI) capabilities with that MAC.

ERAs are only available electronically to providers for a specified period of time after claims adjudication. Your MAC determines the timeframe for RA availability. Therefore, you should confirm the timeline and establish processes to download and save ERA data files on a regular basis. MACs do not distribute SPRs if a provider also receives ERAs for more than 31 days (institutional providers) and 45 days (professional providers/suppliers). If you submit through a billing service or clearinghouse, or a submitter/sender ID that is currently receiving ERAs, you will no longer receive SPRs effective with the completion of the ERA setup date.

WHAT ARE THE BENEFITS OF AN ERA? Using an ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. Trading partners can exchange an ERA with much greater ease than an SPR.

ERA advantages include:

- Faster communication and payment notification
- Faster account reconciliation through electronic posting
- Automation of follow-up action
- Generation of less paper
- Lower operating costs
- Ability to create various reports

- Ability to search for information on claims
- Ability to export data to other applications
- More detailed information
- Access to data in a variety of formats through free software supported by Medicare.

In addition, an ERA can contain more information than an SPR. For example, an SPR contains two basic page layouts: the Claims Page and the Summary Page. However, an ERA contains four page layouts: the All Claims Screen, Single Claim Screen, Bill Type Summary Screen, and Provider Payment Screen.

WHO GETS AN RA?

MACs send RAs to providers, billers, and sometimes to a provider's designated financial institution (if the provider enrolled in EDI). Medicare categorizes providers as either accepting or not accepting assignment.

Providers that accept assignment get payment from a MAC for the claims they submitted, as well as an RA. Providers that do not accept assignment must still submit claims to a MAC for services, procedures, or supplies they furnish to Medicare beneficiaries. The MAC sends payment for those claims to the beneficiary. The provider receives an informational RA to report the amount of payment and the adjustments the MAC made to those claims during adjudication. Providers who do not accept assignment must bill the beneficiary to obtain payment.

HOW DO I VIEW AN RA?

Viewing the ERA The MAC produces the ERA in the Health Insurance Portability and Accountability Act (HIPAA) - compliant X12N 835 format, often referred to as the X12 835 transaction. The X12 835 transaction is for electronic transfers only and the data is not easily readable without a translator. Providers can view and print the information in an ERA using special translator software. For more information on the Medicare standardized data requirement companion guides for the X12N 835, visit Medicare Electronic Billing. Helpful Software for Institutional RAs PC Print software enables institutional providers to print remittance data transmitted by Medicare. MACs are required to make PC Print software available to providers for downloading at no charge, although MACs may charge up to $25 per mailing to recoup costs if the software is sent to providers on a CD/DVD or any other means at the provider's request when the software is available for downloading. This software includes self-explanatory loading and use information for providers. It should not be necessary for you to get formal provider training to use the PC Print software. MACs must supply providers with PC Print software within 3 weeks of request. MACS are required to supply the PC Print software upon request. Your MAC may have more information on their website. Find their website at http://go.cms.gov/MAC-website-list.

WHAT INFORMATION DOES THE RA INCLUDE?

The RA provides detailed payment information about a health care claim(s) and, if applicable, describes why Medicare has not paid the total original charges in full. The RA codes help the provider understand the actions the MACs took while processing the claim(s), and to identify any additional action that may be necessary. For example, some RA codes may indicate a need to resubmit a claim with corrected information, while others may indicate whether the provider may appeal the payment decision. The RA also features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments. An adjustment refers to any change that relates to how a MAC paid a claim differently than the original billing. There are seven general types of adjustments: 1. Denied claim 2. Zero payment 3. Partial payment 4. Reduced payment 5. Penalty applied 6. Additional payment 7. Supplemental payment

The RA uses fields to identify areas of a claim and codes to categorize details of the claim. A field may indicate specific data about the beneficiary, or specific supplies or services the provider rendered. A code represents a standardized reason or condition that relates to the claim or service. The basic elements of the RA can be alphabetic, numeric, or alphanumeric. The HIPAA format standards define these elements as “Required” or “Situational”. The required fields are mandatory and MACs must include them in every RA. Situational fields depend on data content and context (for example, Medicare requirements for a particular service).

ONCE I RECEIVE AN RA, WHAT DO I DO?

When you receive an ERA, you may: • Post decision and payment information automatically, for individual claims in the RA, to the appropriate beneficiary accounts when you are using a compatible provider accounts receivable software application • Identify the reasons for adjustments (denials or payment reductions) • Note when an EFT payment issued with the ERA is scheduled for deposit in the provider’s bank account, or arrange for a deposit of a paper check • Submit a secondary electronic claim that incorporates Medicare adjustment and payment for data from the ERA to other health care plans that cover the beneficiary if the ERA does not indicate that Medicare has issued a COB transaction • Submit a paper secondary claim when appropriate to other health care plans, with an attached print out of the Medicare ERA information • Print for specific payment information, as needed, by using translation software • Avoid future errors by identifying potential problems with the way original claims were submitted When you receive an SPR, you may: • Post manually to accounts receivable • Use it to correct any errors that you may have encountered during claims processing and • Bill secondary health care plans that cover the beneficiary

Electronic Funds Transfer

With Electronic Funds Transfer (EFT), Medicare can send payments directly to a provider’s financial institution whether claims are filed electronically or on paper. All Medicare providers may apply for EFT.

Advantages of EFT

EFT is similar to other direct deposit operations such as paycheck deposits, and it offers a safe modern alternative to paper checks. Providers who use EFT may notice the following benefits:

- Reduction to the amount of paper in the office

- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit a Medicare check
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail
- Faster access to funds; many banks credit direct deposits faster than paper checks
- Easier reconciliation of payments with bank statements.

How to Enroll in EFT

All Medicare contractors include an EFT authorization form in the Medicare enrollment package, and providers can also request a copy of the form after they have enrolled. Providers simply need to complete the EFT enrollment process as directed by their contractor. Medicare payments will be made directly to the financial institution through EFT, in as little as two weeks.

EFT Formats

Medicare contractors can use one of two formats to transmit provider electronic claim payments to financial institutions: Automatic Clearinghouse (ACH) format, or table 1 of the Accredited Standards Committee (ASC) X12 835 version 5010 implementation guide which was adopted as a national standard under HIPAA for electronic payment and remittance advice. Both of these formats are considered national standards.

PC Print

CMS developed the PC-Print software, which gives Medicare Part A facilities a FREE tool to read and print an Electronic Remittance Advice (ERA) in a readable format. Facilities that use the PC-Print software package have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers. The output of PC-Print is similar to the current Standard Paper Remittance (SPR) format.

The PC-Print software enables providers to choose one or more print options:

- Print 835 data in an easily readable format;
- Print the entire transmission;
- View and print provider payment summary information;
- View and print a single claim; and
- View and print a sub-total or summary by bill type.

The PC-Print software and instructions are designed to be self-explanatory for providers. The availability to print out an ERA in the Standard Paper Remittance (SPR) advice format is cost effective. EDISS encourages you to use PC-Print or other software to read, view, and print an ERA to eliminate any need for SPRs.

Benefits of The PC Print Program

Viewing facilities exist to display a Single Claim. Compressed font is incorporated in order to display the detail line item activity of a claim. The All Claims display allows the operator to view all of the claims in a 25 claim count increment, within the transmission in an abbreviated format. The All Claims display allows for left and

right scrolling in order to view the entire Header and Detail of each claim displayed. A Summary Subtotal/Total Bill Type, Bill Summary, displays the sub-totals for each payment category, per provider fiscal year and the total remittance found within the Single Claim display, accumulated and displayed by TOB (Type of Bill). A Payment Summary, Provider Summary, identifies the total paid to the Provider for this billing cycle/transmission. It also indicates the total claims within the billing cycle/transmission. Non-claim payment adjustments are displayed when applicable. These adjustments allow for Provider payments when claims are not present, for example, Periodic Interim Payments, Cost Report Settlements, etc. The adjustments also allow for various other financial transactions required between Fiscal Intermediaries and Providers. The PC Print program allows the end user to view or print all of the above displays. These displays can be done selectively in all situations.

View FISS PC Print File

Remittance Advice (RA) Information Overview

Medicare Appeals Process

Background

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as reconsiderations, be conducted by Qualified Independent Contractors (QICs).

The reconsiderations that are conducted by the QICs have replaced the Hearing officer Hearing process for Medicare Part B claims and established a new second level of appeal for Medicare Part A claims.

Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies (called carriers for Part B, fiscal intermediaries (FIs) for Part A, or Medicare Administrative Contractors (MACs)) to perform many processing functions on behalf of Medicare, including local claims processing and the first level appeals adjudication functions.

NOTE: Medicare Contracting Reform (MCR) Update—In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers.

All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at http://www.cms.hhs.gov/MedicareContractingReform/ on the CMS website.

Appealing Medicare Decisions

- Once an initial claim determination is made, providers, participating physicians and other suppliers have the right to appeal.
- Physicians and other suppliers who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians, or other suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 must be completed and signed by the beneficiary and the non-participating physician or supplier to transfer the beneficiary's appeal rights.
- All appeal requests must be made in writing.
- Five Levels in the Appeals Process
- Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:
- Redetermination by an FI, carrier or MAC
- Reconsideration by a QIC
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter "the Appeals Council")
- Judicial review in U.S. District Court

First Level of Appeal: Redetermination

A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination

A request for a redetermination may be filed on Form CMS-20027 available at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopofPage. A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the

redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

NOTE: Contractors can no longer correct minor errors and omissions on claims through the appeals process. For information on how to correct minor errors and omissions, please see the following MLN Matters article, Se 0420, located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/Se0420.pdf on the CMS website.

Second Level of Appeal: Reconsideration

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Requesting a Reconsideration

A written reconsideration request must be filed within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN. If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the redetermination

The request should clearly explain why you disagree with the redetermination. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

Reconsideration Decision Notification

Reconsiderations are conducted on-the-record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information on further appeals rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

Third Level of Appeal: Administrative Law Judge Hearing

If at least $120* remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

ALJ hearings are generally held by video-teleconference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Appellants may also ask the ALJ to make a decision without a hearing (on-the-record). Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level.

*NOTE: The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold is $120.

Fourth Level of Appeal: Appeals Council Review

If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)

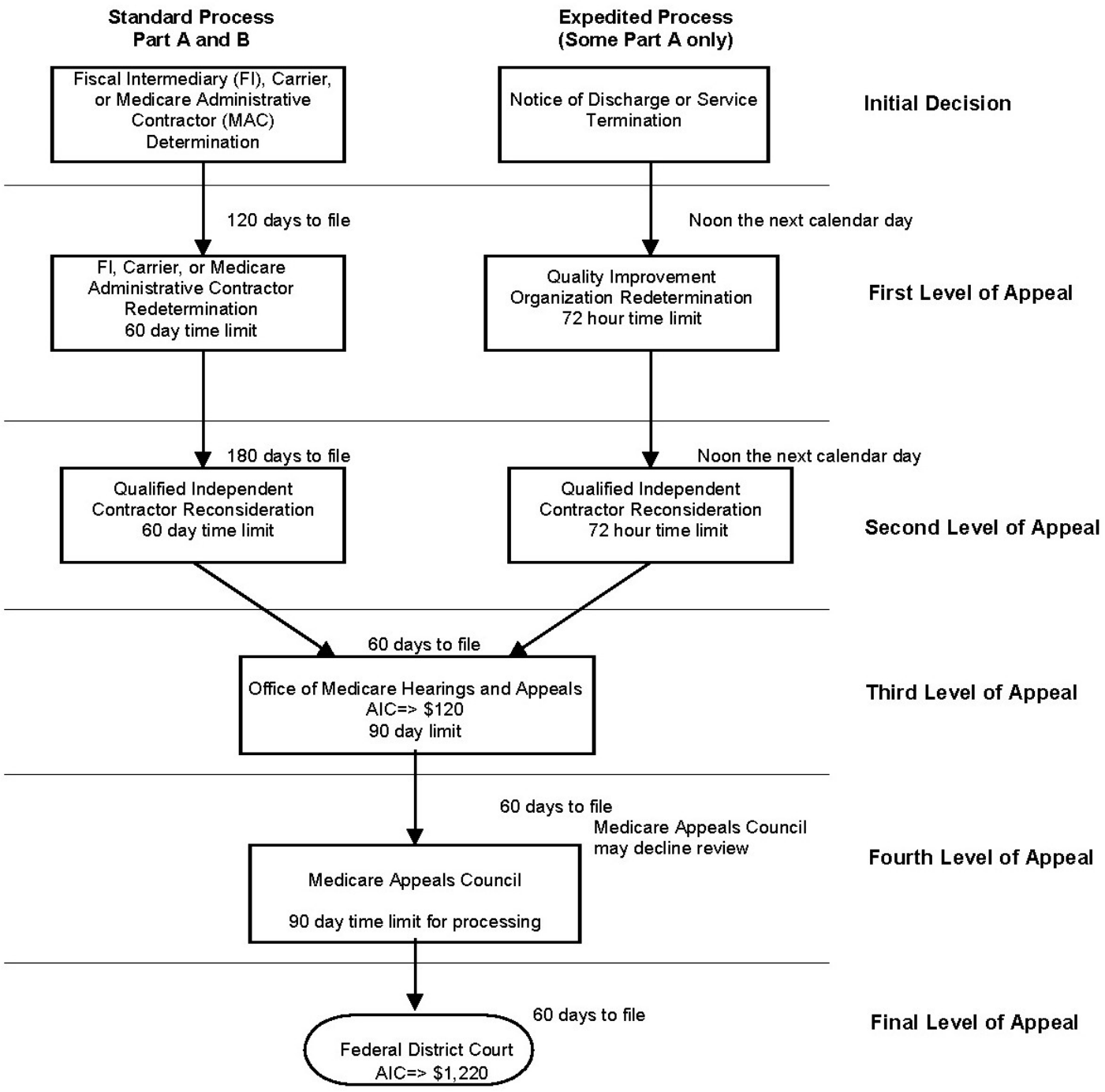
In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable time frame, you may ask the Appeals Council to escalate the case to the Judicial Review level.

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

If at least $1,220* or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

*NOTE: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold is $1,220.

Original Medicare (Parts A and B Fee-For-Service) Appeals Process



AIC = Amount In Controversy