CMS Manual System

Department of Health &
Human Services (DHHS)

Pub 100-04 Medicare Claims Processing

Centers for Medicare &
Medicaid Services (CMS)

Transmittal 1274

Date: JUNE 29, 2007

Change Request 5460

SUBJECT: Appeals of Claims Decisions: Appointment of Representatives; Fraud and Abuse; Guidelines for Writing Appeals Correspondence; Disclosure of Information.

I. SUMMARY OF CHANGES: The purpose of this CR is to notify Medicare contractors about changes to the manual provisions that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

NEW / REVISED MATERIAL

EFFECTIVE DATE: JULY 1, 2007

IMPLEMENTATION DATE: OCTOBER 1, 2007

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D

CHAPTER / SECTION / SUBSECTION / TITLE

R

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III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04

Transmittal: 1274

Date: June 29, 2007

Change Request: 5460

SUBJECT: Appeals of Claims Decisions: Appointment of Representative; Fraud and Abuse; Guidelines for Writing Appeals Correspondence; Disclosure of Information.

EFFECTIVE DATE: July 1, 2007

IMPLEMENTATION DATE: October 1, 2007

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires changes to the 42 Code of Federal Regulations regarding appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

B. Policy: The purpose of this CR is to notify FIs and carriers about changes to the manual provisions that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall" to denote a mandatory requirement

Number

Requirement

Responsibility (place an “X” in each applicable column)

A/
B

MAC

DME

MAC

FI

CARRIER

DMERC

RHHI

Shared-
System
Maintainers

OTHER

FISS

MCS

VMS

CWF

5460.1

Contractors shall comply with the requirements of section 270 for the appointment of representatives.

X

X

X

X

X

X

MSPRC/COBC

5460.2

Contractors shall not accept an appointment of representative if it has evidence that the appointment of representative should not be honored.

X

X

X

X

X

X

MSPRC/COBC

5460.3

Contractors shall send notice to only the appointed representative when the contractor takes action or issues a redetermination if there is an appointed representative.

X

X

X

X

X

X

MSPRC/COBC

5460.4

Contractors shall advise an individual attempting to act as a beneficiary's representative of how to complete the

X

X

X

X

X

X

MSPRC/COBC

Number

Requirement

Responsibility (place an “X” in each applicable column)

A/
B

MAC

DME

MAC

FI

CARRIER

DMERC

RHHI

Shared-
System
Maintainers

OTHER

FISS

MCS

VMS

CWF

appointment when the individual submits an incomplete or defective CMS-1696.

5460.5

Contractors shall not release beneficiary-specific information to a representative before the beneficiary or appellant has signed and completed CMS-1696 or other conforming written instrument naming that individual as his/her representative in accordance with the provisions of the Privacy Act.

X

X

X

X

X

X

MSPRC/COBC

5460.6

Contractors shall comply with the requirements of section 280 in addressing fraud and abuse.

X

X

X

X

X

X

MSPRC/COBC

5460.7

Contractors shall comply with the requirements of section 290 in writing appeals correspondence.

X

X

X

X

X

X

MSPRC/COBC

5460.8

Contractors shall write redetermination letters that are understandable to beneficiaries even when the provider or supplier requests the appeal.

X

X

X

X

X

X

MSPRC/COBC

5460.9

Contractors shall write in plain English/plain language with a clear, simple, conversational writing style with good communication of key points.

X

X

X

X

X

X

MSPRC/COBC

5460.10

Contractors shall get reading levels of letters as low as possible without losing important content or distorting the meaning and without sounding condescending to the reader.

X

X

X

X

X

X

MSPRC/COBC

5460.11

Contractors shall comply with the requirements of section 300 for the disclosure of information

X

X

X

X

X

X

MSPRC/COBC

5460.12

Contractors shall follow the MSP specific limitations or additional requirements in section 270.3.

X

X

X

X

X

X

MSPRC/COBC

III. PROVIDER EDUCATION TABLE

Number

Requirement

Responsibility (place an "X" in each applicable column)

A/
B

DME

FI

CAR

DME

RHH

Shared-
System
Maintainers

OTHER

FISS

MCS

VMS

CWF

5460.13

Option 2: A provider education article related
to this instruction will be available at
http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will
receive notification of the article release via
the established "MLN Matters" listserv.

Contractors shall post this article, or a direct
link to this article, on their Web site and
include information about it in a listserv
message within one week of the availability
of the provider education article. In addition,
the provider education article shall be
included in your next regularly scheduled
bulletin. Contractors are free to supplement
MLN Matters articles with localized
information that would benefit their provider
community in billing and administering the
Medicare program correctly.

X

X

X

X

X

X

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref

Requirement

Number

Recommendations or other supporting information:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Maria Ramirez at Maria.Ramirz@cms.hhs.gov or Charlayne Van at Charlayne.Van@cms.hhs.gov.

Post-Implementation Contact(s): Maria Ramirez at Maria.Ramirz@cms.hhs.gov or Charlayne Van at Charlayne.Van@cms.hhs.gov.

VI. FUNDING

A. For TITLE XVIII Contractors, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), Coordination of Benefits Contractor (COBC) and its Medicare Secondary Payer Recovery Contractor (MSPRC), use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Claims Processing Manual

Chapter 29 - Appeals of Claims Decisions

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270 - Appointment of Representative

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

(See 42 CFR 405.912, "Appointment of Representative.")

NOTE: See also Section 270.3, "Medicare Secondary Payer (MSP) Specific Limitations or Additional Requirements With Respect to the Appointment of Representatives."

270.1.1 - Appointment of Representative - Introduction

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the contractor. Although some parties may pursue a claim or an appeal on their own, others will rely upon the assistance and expertise of others. A representative may be appointed at any point in the appeals process. A representative may help the party during the processing of a claim or claims, and/or any subsequent appeal. (See §270.1.10 for information on disclosing information to third parties) The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative.

NOTE: A representative must sign the appointment within 30 calendar days of the

party's signature. The appointment remains valid for any subsequent levels of appeal on the item/service in question unless the beneficiary specifically withdraws the representative's authority. (See §270.1.3.) New appeals may be initiated by the representative within the 1-year timeframe. To initiate a new appeal within the 1-year timeframe, the representative must file a copy of the CMS-1696, or other conforming written instrument, with the appeal request. In order for the appointment to be valid, it must be signed and dated by the beneficiary.

270.1.2 - Who May Be a Representative

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Any individual may be appointed to act as a representative unless he/she is disqualified, suspended, or otherwise prohibited by law from acting as a representative in proceedings before DHHS, or in entitlement appeals, before SSA. A contractor should not accept an appointment of representative if it has evidence that the appointment of representative should not be honored. It should notify the party attempting to be represented and the individual attempting to represent the party that the appointment will not be honored.

A specific individual must be named as the representative. An organization or entity may

not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that confidential beneficiary information is released only to the individual so named.

A provider or supplier who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative of the beneficiary. To act as the beneficiary's representative, the provider or supplier must meet the criteria set forth in this section.

If the requestor is the beneficiary's legal guardian, surrogate decision-maker for an incapacitated beneficiary, or otherwise authorized under State law, no appointment is necessary, and the requestor is defined as the authorized representative.

NOTE: Billing clerks or billing services employed by the provider or supplier to prepare and/or bill the initial claim, process the payments, and/or pursue appeals act as the agent of the provider or supplier and do not need to be appointed as representative of the

provider/supplier. Include evidence in the case file if the physician or other supplier employs a billing clerk or billing service (a screen print showing that payment is made to the billing clerk or billing service is sufficient.) If the billing clerk/billing service is not authorized to receive payment, but is authorized to process payments and/or pursue appeals, include evidence in the case file. If the agreement is on file, make a note in the case file where the agreement can be located. (See the Medicare General Information, Eligibility, and Entitlement Manual, which allows payment to be made to an agent who furnishes billing or collection services.)

The following is a list of the types of individuals who could be appointed to act as representative for a party to an appeal. This list is not exhaustive, and is meant for illustrative purposes only:

• Congressional staff members;
• Family members of a beneficiary;
• Friends or neighbors of a beneficiary;
• Member of a beneficiary advocacy group;
• Member of a provider or supplier advocacy group;
• Attorneys; and
• Physicians or suppliers.

270.1.3 - How to Make and Revoke an Appointment

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (CMS-1696) or use a conforming written instrument (see subsection B below, for required elements of written instruments). A party may appoint a representative at any time during the course of an appeal. The representative must sign the CMS-1696 or other conforming written instrument within 30 calendar days of the date the beneficiary or other party signs in order for the appointment to be valid. (See subsection A, below, for exceptions.) By signing the appointment, the representative indicates his/her acceptance of being appointed as representative.

A. Completing a valid Appointment of Representative (CMS-1696)

The CMS-1696 is available for the convenience of the beneficiary or any other party to use when appointing a representative. Following are instructions for completing the form.

1. The name of the party making the appointment must be clearly legible. For beneficiaries, the Medicare number must be provided.

2. Completing Section I – “Appointment of Representative”-A specific individual must be named to act as representative in the first line of this section; a party may not

appoint an organization or group to act as representative. The signature, address, and phone number of the party making the appointment must be completed, and the date it was signed must be entered. Only the beneficiary or the beneficiary's legal guardian may sign when a beneficiary is making the appointment. If the party making the appointment is the provider or supplier, someone working for, or acting as an agent of, the provider or supplier must sign and complete this section.

3. Completing Section II – "Acceptance of Appointment"- The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed then signs and completes the rest of this section.

4. Completing Section III – "Waiver of Fee for Representation"- This section must be completed when the beneficiary is appointing a provider or supplier as representative and the provider or supplier actually furnished the items or services that are the subject of the appeal.

5. Completing Section IV – "Waiver of Payment for Items or Services at Issue" – This section must be completed when the beneficiary is appointing a provider or supplier who actually furnished the items or services that are the subject of the appeal and involve issues describe in section 1879(a)(2) of the Act.

If any one of the elements listed above is missing from the appointment, the adjudicator shall contact the party (individual attempting to act as a beneficiary's representative) and provide a description of the missing documentation or information. Unless the defect is cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision. The adjudicator shall not dismiss the appeal request because the appointment of representative is not valid.

Prohibition Against Charging a Fee for Representation

A provider or supplier that furnished items or services to a beneficiary may represent

that beneficiary on the beneficiary's claim or appeal involving those items or services. However, the provider or supplier may not charge the beneficiary a fee for representation in this situation. Further, the provider or supplier representative being appointed as representative must waive any fee for such representation. The provider or supplier representative does this by completing section III of the CMS-1696. Alternatively, the provider or supplier must include a statement to this effect on any other conforming written instrument being used, and must sign and date the statement.

Waiver of Right to Payment for the Items or Services at Issue

For beneficiary appeals involving the denial of the claim on the basis of §1862(a)(2) of the Act, and where a knowledge determination made under §1879 of the Act (i.e., a limitation on liability determination) and where the provider or supplier that

furnished the items or services at issue is also serving as the beneficiary's representative, the provider or supplier must waive, in writing, any right to payment from the beneficiary for the items or services at issue (including coinsurance and deductibles). The provider or supplier representative does this by completing section IV of the CMS-1696 or other conforming written instrument, and must sign and date the statement.

The prohibition against charging a fee for representation, and the waiver of right to payment from the beneficiary for the items or services at issue, do not apply in those situations in which the provider or supplier merely submits the appeal request on behalf of the beneficiary or at the beneficiary's request (i.e., where the provider or supplier is not also acting as representative for the beneficiary), or where the items or services at issue were not provided by the provider or supplier representative.

B. Revoking an Appointment

The party appointing a representative may revoke the appointment by providing a written statement of revocation to the contractor at any time.

270.1.4 - When to Submit the Appointment

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A representative, beneficiary, or other party may submit the completed appointment to the contractor at the time such person files a request for appeal or at any time during the processing of the appeal. If an appeal or other motion is filed by a representative on behalf of a party to the appeal, but does not include an appointment, the contractor takes the actions specified below in §270.1.8 to secure the written appointment.

If a valid CMS-1696, or other conforming written instrument, has previously been filed with the contractor and remains valid within the time frames of §270.1.7, the representative need not submit a copy with future requests at higher levels of appeal. If a new appeal is initiated during the 1-year timeframe of the appointment, a copy of the appointment must be filed with the appeal request.

270.1.5 - Where to Submit the Appointment

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When the appellant or representative submits the original or a copy of the signed CMS-1696 or other conforming written statement to the contractor, the contractor places it in the case file. The representative should also give the party making the appointment a copy of the completed form.

270.1.6 - Rights and Responsibilities of a Representative

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In representing an appellant before a contractor, the representative has certain rights and responsibilities.

A. Authority of an Appointed Representative

A representative may represent a party in an appeal of a claim. An appointed representative may, on behalf of the party; obtain appeal information about the claim to the same extent as the party, submit evidence, make statements about facts and law, and make any request, or give or receive, any notice about the appeal proceedings.

When a contractor takes action or issues a redetermination, it shall send notice to only the appointed representative. Notice shall not be sent to the party if there is an appointed representative.

The contractor shall send any requests for information or evidence regarding an appeal only to the appointed representative.

See also, section 270.3 for MSP specific requirements.

B. Responsibilities of an Appointed Representative

An appointed representative must-

• Inform the party of the scope and responsibilities of the representation.
• Inform the party of the status of the appeal and the results of actions taken on behalf of the party such as notification of appeal determinations, decisions, and further appeal rights.
• Disclose to a beneficiary any financial risk and liability of a non-assigned claim that the beneficiary may have.
• Not act contrary to the interest of the party, and
• Comply with all laws and CMS regulations, CMS Rulings, and instructions.

The appointment of a representative by a party must be made freely and without coercion. The contractor should assume that a representative is not making false or misleading statements, representations, or claims about any material fact affecting any person’s rights. However, if the contractor has reason to believe that the representative is making false or misleading statements, representations or claims about any material fact affecting any persons rights, it should refer the matter to the Program Safeguard

Contractor (PSC). A representative will have access to personal and confidential medical and other information about a beneficiary(ies). The contractor may assume that the representative will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it may assume that a representative is not disclosing any personal or confidential medical or other information about a beneficiary(ies) outside of the appeals process.

Unless otherwise directed by the party making the appointment, the contractor need not keep the represented party informed of the purpose of the appointment, the scope of the appointment, and exactly when/under what circumstances the appointment will be

exercised, since it may assume the representative has taken on this responsibility. Further, the representative should keep the party informed on the progress of an appeal.

C. Delegation of Appointment by Appointed Representative

An appointed representative may delegate the appointment if the following conditions are met;

• The appointed representative provides written notice to the party of the appointed representative's intent to delegate to another individual. The notice must include the name of the designee and the designee's acceptance to be obligated and comply with the requirements or representation under this subpart.
• The party accepts the designation by signing a written statement to that effect.
This signed statement is not required when the appointed representative and designee are attorneys in the same law firm or organization.

270.1.7 – Duration of Appointment

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

An appointment is considered valid for 1 year from the date that the CMS-1696 or other conforming written instrument contains the signatures of both the party and appointed representative. For the administrative convenience of both the party making the appointment and the representative, the representative may maintain a completed appointment on file and then submit a copy with each new appeal request. (See subsections below for more detail.)

Allowing the representative to use the same appointment for up to one year will help reduce the paperwork involved in representing parties. Requiring that a new appointment be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.

Upon receipt of an appointment, the contractor may notify the representative of the need to complete a new appointment on a yearly basis. This will make both the party making the appointment and the representative aware of the need for annual filing of an appointment. The contractor may also place information about appointment validity in provider newsletters, bulletins, educational materials, etc.

The appointment remains valid throughout any and all subsequent levels of administrative appeal on the claim or claims at issue. Therefore, the representative need not secure a new appointment when proceeding to the next level of appeal on the same claim(s). This holds true regardless of the length of time it may take to resolve the appeal. The appointed representative may also file new appeals during the 1 year duration of the appointment, and shall submit a copy of the CMS-1696, or other conforming written instrument, with the appeal request.

270.1.8 – Curing a Defective Appointment of Representative

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If any one of the required elements named in §270.1.3 is missing, the contractor shall contact the party (the individual attempting to act as the beneficiary's representative) and provide a description of the missing documentation or information. If the defect is not cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

Handling these situations depends on who (what party) is attempting to make an appointment. When the beneficiary makes the appointment, the contractor provides help and assistance to the beneficiary and representative in securing the appointment, based on the time frames set forth below. When a provider or physician or other supplier makes the appointment, the contractor provides instruction on the proper and timely completion of the appointment. The following provides guidance on properly responding to a representative's attempt to submit a request for appeal.

A. Timely Filed Appeal Request With a Appointment Missing or Defective

There are different rules for missing appointments versus defective appointments.

1. Missing or Defective Appointment When Beneficiary is the Represented Party

When an individual is attempting to act as beneficiary's representative, but submits an incomplete or defective CMS-1696 or other conforming written instrument, the contractor shall advise the individual of how to complete the appointment, and shall notify the individual to submit the completed appointment to the contractor based on the time limits below. The contractor shall include in the notice any relevant information the individual should know if the individual fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, will not be the official representative). Should the CMS-1696 or written instrument not be corrected within the time limits set forth below, the contractor proceeds with processing and rendering a decision on the appeal. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the unauthorized representative. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent. However, if the contractor has information or evidence that the appointment was not

submitted at the request of the beneficiary, it shall not conduct the appeal unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

When an individual is attempting to act as a representative of an appellant who is a beneficiary but fails to complete CMS-1696 or other conforming written instrument, the contractor considers the missing appointment to be an incomplete form or written statement and follows the instructions above. In cases of appeals filed on behalf of the beneficiary, the contractor need not develop an absent appointment of representative if

the request for redetermination clearly shows the beneficiary knew of or approved the submission of the request for redetermination.

When there is information or evidence that the appeal request and/or the appointment of representative was not submitted at the request of the beneficiary, the contractor shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary). In order to verify the wishes of the beneficiary, the contractor may have to send a letter to the beneficiary explaining the situation. The letter shall advise that if no response is received then the appointment of representative will not be honored.

The contractor notifies both the alleged representative and the party of the incomplete or defective CMS-1696 or other conforming written instrument and describes the documentation/missing information that is required to execute a valid form or statement. It allows 14 calendar days for a corrected appointment to be submitted. If, at the end of the time allowed a corrected appointment has not been submitted, the contractor takes the appropriate action.

2. Defective or Missing Appointment When Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party

In cases where the beneficiary is not the represented party, the contractor notifies both the person submitting the appointment and the appellant of the incomplete appointment. It advises the party why the appointment is defective, and describes the documentation or missing information that is required to complete the appointment. This may be done by telephone or written notification. A corrected/completed appointment may be submitted to the contractor by facsimile, at the contractor's discretion, or by mail within 14 days. Should the CMS-1696 or other conforming written instrument not be corrected within the time limit, the contractor dismisses the appeal request and notifies, in writing, both the appellant and the person submitting the appointment of the contractor's dismissal. Further, the dismissal shall state that an appeal request may be resubmitted by anyone (including the representative if the representative has properly completed the appointment) if the time limit for submitting the appeal has not expired.

If the individual is attempting to act as a representative of an appellant who is not the beneficiary and fails to include a CMS-1696 or other conforming written instrument with the appeal request, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Appointment

Because an untimely-filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing), an incomplete or defective CMS-1696 or other conforming written instrument may, in some cases, need to be corrected. If an incomplete or defective appointment needs to be corrected, the contractor follows the instructions contained in §270.1.8, above, prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Appointment

These cases should be resolved solely on the basis of whether there is good cause. (See §240.1.)

270.1.9 - Incapacitation or Death of Beneficiary

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If at any time after the execution of a valid appointment or nondurable power of attorney the beneficiary becomes incapacitated and is unable to manage his/her affairs, the appointment becomes invalid. The contractor shall resolve who has legal authority to act on behalf of the beneficiary before disclosing any further information pursuant to the appointment or nondurable power of attorney.

If the beneficiary has executed a durable power of attorney that authorizes the designated person to conduct the beneficiary's affairs, or to make financial decisions on behalf of the beneficiary, the representation does not become invalid upon the beneficiary's subsequent incapacitation.

NOTE: Some durable powers of attorney do not become effective until and unless such an incapacitation occurs.

The death of a party terminates the authority of the appointed representative. However, if an appeal is in progress and another individual or entity may be entitled to receive or obligated to make payment for the items or services that are the subject of the appeal, the appointment remains in effect for the duration of the appeal. See also, section 270.3 for MSP specific limitations or additional requirements.

If the beneficiary is deceased, the legal representative of the estate may file the request. In the absence of a legal representative, any person who has assumed responsibility for settling the decedent's estate may file it. In these situations, the contractor shall obtain proof that the person has assumed responsibility for settling the decedent's estate (e.g., a

will or probate court document). What is acceptable as legal documentation may vary according to State law. The contractor shall notify the person filing the appeal about the documentation needed to show the person is either the legal representative of the estate or the person who has assumed responsibility for settling the decedent's estate and describe the types of documentation needed. Allow at least 14 calendar days for the documentation to be submitted. If, at the end of the time allowed, the documentation needed is not submitted, dismiss the request. If the appellant submits the documentation after the allotted time, the contractor considers good cause for late filing. In such instances, the contractor documents the file to show the basis for that person’s filing the appeal.

270.1.10 - Disclosure of Individually Identifiable Beneficiary Information to Representative

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In accordance with the provisions of the Privacy Act, before the contractor may release beneficiary-specific information to a representative, the beneficiary or appellant must complete and sign CMS-1696, or other conforming written instrument, naming that individual as his/her representative. The contractor shall use caution in releasing beneficiary-specific information to representatives. The representative is entitled to receive only information that the party (beneficiary or appellant) would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which the representative is being appointed.

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

270.2 – Assignment of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

(See 42 CFR 405.912, "Assignment of Appeal Rights.")

270.2.1 – Assignment of Appeal Rights – Introduction

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A beneficiary may assign his or her appeal rights to a provider or supplier who furnished an item or service to the beneficiary that is at issue in an appeal. Only providers or suppliers who are not a party to the initial determination may accept assignment of appeal rights from a beneficiary (See §210 for information on who is a party to an appeal.)

Because beneficiaries have difficulty understanding the term "assignment of appeal rights", we use the term "transfer of appeal rights" on the related form and for communication to beneficiaries. For the remainder of these instructions, we will also use the term "transfer" instead of "assignment" of appeal rights, whenever appropriate.

The transfer of appeal rights is valid for the duration of the appeal, unless revoked by the beneficiary.

270.2.2 - Who May Be an Assignee

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Only a provider or supplier that is not a party to the initial determination and furnished an item or service to the beneficiary may accept the transfer of a beneficiary's appeal rights for that item or service.

An individual or entity who is not a provider or supplier may not accept the transfer. A provider or supplier that furnishes an item or service to a beneficiary may not accept the transfer for that item or service when considered a party to the initial determination.

270.2.3 - How to Make and Revoke a Transfer of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The beneficiary making the transfer (assignor) and the provider or supplier accepting the transfer (assignee) must complete the CMS standardized Transfer of Appeal Rights form (Form CMS-20031). This form is entitled, "Transfer of Appeal Rights". No alternative written instrument may be used. The assignee must sign the CMS-20031 within 30 calendar days of the date the beneficiary signs in order for the transfer to be valid.) By signing the CMS-20031, the provider indicates his/her acceptance of being the assignee. Page two of the form provides information to the beneficiary about transferring appeal rights.

A. Completing a valid Transfer of Appeal Rights Form CMS-20031

Form CMS-20031, Transfer of Appeal Rights, is the required form that beneficiaries must use to assign their appeal rights. Following are instructions for completing the form. "Transfer of Appeal Rights," Form CMS-20031)

1. The name of the beneficiary transferring appeal rights must be clearly legible.
The beneficiary's Medicare number must be provided.

2. Completing Section I – "Transfer of Appeal Rights"-The beneficiary must complete this section. This section includes name, Medicare number, address and phone number, and the item or service that is at issue. The beneficiary must sign the transfer statement and include the date. Only the beneficiary may sign this section.

3. Completing Section II – "Acceptance of Appeal Rights"- The provider or supplier accepting the appeal rights must complete this section. This section includes name, address, phone number. The provider or supplier must sign this section to accept the transfer of appeal rights and agree not to collect payment from the beneficiary for the item or service at issue, except for any applicable deductible or coinsurance, or if a valid Advance Beneficiary Notice (ABN) is in effect.

4. If the form is not complete the adjudicator should contact the party and provide a description of the missing information. Unless the defect is cured, the provider or supplier lacks the authority to accept the appeal rights of the beneficiary, and is not

entitled to take action regarding the appeal or obtain or receive any information related to the appeal, including the appeal decision. The adjudicator should not dismiss the appeal request because the transfer of appeal rights is not valid.

B. Waiver of Right to Payment for the Items or Services at Issue

The provider or supplier who accepts the appeal rights must waive the right to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form. The waiver to collect payment remains in effect regardless of the outcome of the appeal decision.

This waiver remains valid unless the transfer is revoked by the beneficiary as described in subsection D, below.

C. Duration of a Valid Transfer of Appeal Rights

Unless revoked, the transfer of appeal rights is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary.

D. Revoking a Transfer of Appeal Rights

The party appointing a representative may revoke the transfer of appeal rights by providing a written statement of revocation to the adjudicator at any time. If revoked, the rights to appeal revert to the beneficiary. The transfer may be revoked in the following ways:

1. In writing by the beneficiary. The revocation must be delivered to the adjudicator and the provider or supplier and is effective on the date or receipt by the adjudicator.

2. By abandonment if the assignee does not file an appeal of an unfavorable decision.

3. By an act or admission by the assignee that is determined by an adjudicator to be contrary to the financial interests of the beneficiary.

270.2.4 - When to Submit the Transfer of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A provider or supplier may submit the completed transfer of appeal rights form to the contractor at the time he or she submits an appeal request. The provider or supplier may obtain the completed transfer of appeal rights form from the beneficiary at the time that the services are provided, and file the previously signed form with the appeal.

270.2.5 - Where to Submit the Transfer of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When the provider or supplier submits the original or a copy of the signed transfer of appeal rights form, the contractor shall place it in the case file. The provider or supplier should also give the beneficiary a copy of the completed form.

270.2.6 – Rights of the Assignee of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When a valid transfer of appeal rights is executed, the beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier.

The transfer of appeal rights by a beneficiary must be made freely and without coercion. The contractor shall assume that a provider or supplier is not making false or misleading statements, representations or claims about any material fact affecting any person's rights. However, if the contractor has reason to believe that the assignee is making false or misleading statements, representations or claims about any material fact affecting any person's rights, it shall refer the matter to the PSC. A provider or supplier accepting the transfer of appeal rights will have access to personal and confidential medical and other information about a beneficiary. The contractor shall assume that the provider or supplier will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it shall assume that a provider or supplier is not disclosing any personal or confidential medical or other information about a beneficiary outside of the appeals process.

A beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier, these include, but are not limited to-

1. Obtaining information about the claim to the same extent as the beneficiary;
2. Submitting evidence;
3. Making statements about facts or law; and
4. Making any request, or giving , or receiving any notice about appeal proceedings.

When a contractor takes action or issues a redetermination, it shall send notice to only the assignee. Notice shall not be sent to the beneficiary if there is an assignee.

The contractor shall send any requests for information or evidence regarding an appeal only to the assignee.

270.2.7 – Duration of Transfer of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Unless revoked the transfer of appeal rights is valid for all levels of appeal including judicial review. This transfer remains in effect even in the event of the death of the beneficiary.

270.2.8 – Curing a Defective Transfer of Appeal Rights

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If any one of the elements is missing from the CMS-20031, the contractor shall contact the party and provide a description of the missing documentation or information. If the defect is not cured, the prospective assignee of appeal rights lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

The contractor shall provide help and assistance to the beneficiary and provider or supplier in securing the transfer of appeal rights, based on the time frames set forth below.

A. Timely Filed Appeal Request With a Transfer, Missing or Defective

Missing or Defective Transfer of Appeal Rights

The contractor shall notify both the provider/supplier submitting the CMS-20031 and the beneficiary. The contractor shall advise them why the transfer is defective, and describes the missing information that is required to complete the transfer. This may be done by telephone or written notification. A corrected/completed transfer may be submitted to the contractor by facsimile, at the contractor's discretion, or by mail within 14 days. Should the CMS-20031 not be corrected within the time limits set forth below, the contractor proceeds with processing and rendering a decision on the appeal. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the unauthorized assignee. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent. However, if the contractor has information or evidence that the transfer was not submitted at the request of the beneficiary, it shall not conduct the appeal unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Transfer

Because an untimely-filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing, see §240.1), an incomplete or defective CMS-20031 may, in some cases, need to be corrected. If an incomplete or defective CMS-20031 needs to be corrected, the contractor shall follow the instructions contained in Section A, above prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Transfer

These cases should be resolved solely on the basis of whether there is good cause. (See §240.1.)

270.2.9 - Disclosure of Individually Identifiable Beneficiary Information
to Assignees

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In accordance with the provisions of the Privacy Act, before the contractor may release
beneficiary-specific information to an assignee, the beneficiary must complete and sign
an CMS-20031 naming that individual as his/her assignee. The contractor shall use

caution in releasing beneficiary-specific information to assignees. The assignee is entitled to receive only information that the beneficiary would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which the assignee being appointed.

A beneficiary must explicitly authorize the release of any information that is not specific to the case/claim for which the assignee has been appointed. Any questions as to whether information needs authorization to be released to an assignee can be directed to the appropriate RO.

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

270.3 - Medicare Secondary Payer (MSP) Specific Limitations or Additional Requirements

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following instructions/rules apply with respect to MSP recovery claims, not withstanding any language to the contrary in other subsections of "Section 270 Appointment of Representative."

For a MSP recovery claim involving a beneficiary debtor, the representative relationship typically arises in the context of the beneficiary's claim against a workers' compensation plan, liability insurance (including self-insurance), or no-fault insurance. The representative is not hired solely to represent the beneficiary with respect to the recovery demand letter/debt at issue on appeal; the representative is routinely hired in connection with an underlying liability, no-fault or workers' compensation claim.

For MSP recovery claims involving a debtor other than a beneficiary or a provider/supplier, follow the instructions in the MSP IOM, Pub. 100-05, Chapter 7, section 10, regarding authorization to represent a debtor. For MSP recovery claims

involving a provider/supplier debtor, follow the instructions for non-MSP.

The instructions below contain exceptions or additions to the non-MSP rules for MSP recovery claims involving a beneficiary debtor.

A. Appointment of Representative

For MSP recovery claims involving a beneficiary debtor, the representative relationship may be established in the following ways (the document must always include the beneficiary's HICN as well as his/her name):

1. If the representative is an attorney, by –

• A copy of the fee agreement between the beneficiary and the attorney, signed by the beneficiary and signed/countersigned by the attorney,

• A statement on the attorney's letterhead accompanied by a release signed by the beneficiary, or

• A document compliant with the non-MSP rules.

2. If the representative is a non-attorney, follow the non-MSP rules. However, note that information may be released to a non-representative regardless of whether or not there is a proper appointment of representative if the individual or entity has a proper HIPAA compliant release from the beneficiary.

B. Duration of Appointment

The duration of the appointment lasts until revoked by the beneficiary absent specific language in the appointment document limiting the duration of appointment. This is true regardless of whether or not an appeal has been filed within 1 year of the date of the appointment.

C. Correspondence

Both the beneficiary and the representative shall receive copies of all correspondence (including all appeals determinations).

D. Death of a Beneficiary

The death of the beneficiary terminates the authority of any representative appointed by the beneficiary. The representative must obtain a new appointment from the beneficiary's estate or the individual assuming responsibility for the estate if there is no formally appointed executor.

280 - Fraud and Abuse

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

280.1 - Fraud and Abuse – Authority

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

To protect the Medicare program from fraud and abuse, civil and criminal violation provisions have been included in §§1107, 1128A, 1128B, 1872, and 1877 of the Act.

280.2 - Inclusion and Consideration of Evidence of Fraud and/or Abuse

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The contractor shall inquire fully into the matters at issue by receiving, in evidence, the testimony of witnesses and any documents that are relevant to the claims at issue. If the contractor believes that evidence has been tampered with it shall refer this documentation to either the medical review or the PSC units for their follow-up.

The contractor may receive evidence obtained and provided by the PSC concerning fraud or potential fraud with respect to the claim(s) at issue. If the PSC provides such evidence, it becomes part of the case file and must be made available for inspection by the appellant prior to the reconsideration. Evidence of this character is to be evaluated to determine issues such as whether, in conjunction with other credible evidence, the services in question were actually provided or were provided as billed.

280.3 - Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Where there is a substantial basis for determining that an item or service either was not furnished or was not furnished as billed, the contractor may deny or down-code payment, as appropriate. The reviewer must ensure that the case file clearly documents the evidence that formed the basis for the determination. Appeal rights after such a determination remain the same as they would for any other unfavorable decision. If the contractor has reason to believe or evidence to support that items or services were not furnished or were not furnished as billed, it shall send a copy of the decision to its PSC.

280.4 - Responsibilities of Adjudicators

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If, during the course of the redetermination, the reviewer suspects a civil or criminal law violation, the reviewer shall render a decision only on the coverage or payment issues

raised by the redetermination request. Although the reviewer cannot make a determination of civil or criminal fraud, he/she may still deny or reduce payment if he/she believes that the items or services at issue were not rendered, or were not rendered as billed (as discussed above). In making this determination the reviewer may consider all available evidence, including witness testimony, medical records, and evidence compiled through a fraud investigation, as discussed above. (See §310.4 (B), below.) In addition to denying the claims because the services were not rendered as billed, if the reviewer suspects fraud, he/she shall forward information regarding the potential civil or criminal violation to the PSC. For further discussion on the Medicare fraud, see the Medicare Program Integrity Manual at: http://www.cms.hhs.gov/manuals/108_pim/pim108toc.asp

280.5 - Requests to Suspend the Appeals Process

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The contractor does not have the authority to suspend redeterminations at the request of the Office of the Inspector General (OIG) or the Department of Justice (DOJ) without approval and direction from central office (CO). If the OIG or DOJ submits such a request to suspend a review or hearing, the contractor shall first bring that request to the attention of CO through the RO.

280.6 - Continuing Appeals of Providers, Physicians, or Other Suppliers Who are Under Fraud or Abuse Investigations

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Reviewers shall continue adjudicating the appeals of Medicare claims submitted by a provider, physician, or other supplier who is being or has been investigated, indicted, or convicted for fraud or abuse on other Medicare claims, or who is on Medicare payment suspension, unless the contractor has been informed that the provider, physician, or other supplier has agreed, as part of a settlement with the Government, or as the result of a prosecution, to withdraw the appealed claims or to waive the right to appeal the subject claim(s). If it has received notice of such a settlement, the contractor shall dismiss the appeal based on the fact that the appellant has waived his/her/its right to an appeal, and/or agreed to withdraw appeal of these claims as part of a settlement agreement with the Government. The contractor places a copy of the settlement document or other evidence of a settlement in the file. A reviewer shall remain neutral in the adjudication of claims that involve a provider, physician, or other supplier who is being or has been investigated, indicted or convicted of fraud or abuse.

280.7 - Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The appeals process remains in effect for all claims with service dates prior to the effective date of exclusion, and any appeal rights of an excluded provider, physician, or other supplier may be exercised following the normal administrative appeals process.

The appeal rights of a beneficiary are present for all claims with service dates prior to the effective date of the exclusion, as well as for claims with service dates after the date of exclusion.

290 - Guidelines for Writing Appeals Correspondence

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The guidelines in this section are to be used when preparing appeals correspondence, which includes redeterminations decisions and inquiries about the status of appeals. These shall be handled as expeditiously as possible without lowering the quality of the response. General instructions on responding to beneficiary and provider/supplier communications are found in CMS Medicare Pub. 100-9. All other CMS-issued instructions on correspondence guidelines apply as well, including instructions on correspondence letterhead requirements.

290.1 - General Guidelines

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Contractors shall prepare appeals correspondence so the appellant can easily understand both the reason why any of the services were not covered or could not be fully reimbursed, and what action the appellant can take if the appellant disagrees with that decision. In addition, the following guidelines should be followed to the extent possible:

- Keep the language as simple as possible;
- Do not use abbreviations or jargon;
- Choose a positive rather than a negative tone, whenever possible. Avoid words or phrases that emphasize what cannot be done by the contractor or the appellant;
- If possible, avoid one sentence paragraphs, uneven spacing between paragraphs, etc;
- Apologize when appropriate, e.g., if the response is late. However, do not apologize for enforcing Medicare guidelines that may be adverse to the appellant's claim;
- Summarize the question before providing a response; and,
- Use correct spelling, grammar, and punctuation.

290.2 - Letter Format

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Appeals correspondence shall follow the instructions issued by CMS for contractor written correspondence letterhead requirements unless otherwise instructed and/or agreed to by CMS.In addition, please note the following:

- Numerical dates must not be used (i.e., instead of 6/16/98, use June 16, 1998);
- Type/font size smaller than 12 point must not be used (all responses are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another style for the ease of reading by the beneficiary and the provider);
- When the subject matter is lengthy or complicated, bullet points should be used to clarify, if possible;

• For long letters, headings should be used to break it up (e.g., DECISION, BACKGROUND, RATIONALE);
• If procedure codes are cited, the actual name of the procedure must be associated with the code;
• Span dates may not be used for 1 day of service; and
• Letters that contain all capital letters appear impersonal and computer generated. The contractor should not use all capital letters.

Where the request for appeal involves multiple beneficiaries, the contractor shall produce separate decision or redetermination letters. This way, on requests with multiple beneficiaries each beneficiary is provided with a copy of their own determination without compromising the privacy of other beneficiaries' claims in the appeal. However, you can continue to send one consolidated letter to the provider.

290.3 - How to Establish Reading Level

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The MMA requires that appeals correspondence be written in a manner calculated to be understood by beneficiaries. Contractors shall write appeals correspondence that is understandable to beneficiaries. The purpose of this section is to provide some guidance to contractors on writing letters that are easy for beneficiaries to understand. To achieve this goal, contractors shall:

(1) Write in plain English/plain language with a clear, simple, conversational writing style with good communication of key points.

(2) Get reading levels of letters as low as you can without losing important content or distorting the meaning and without sounding condescending to the reader.

NOTE: This requirement does not apply to providers. Contractors can use a cover sheet for the beneficiary, when sending a copy of the decision.

290.3.1 - Writing in Plain Language

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following are some tips to help contractors to write letters in plain language:

• Include definitions or explain terms you must use that are not familiar with your intended audience.

• Use heading, subheadings, or other devices to signal what's coming next. Labels for sections, headings, and subheading should be clear and informative to the intended audience.

• Write in an active voice and in a conversational style. For example, conversational style uses contractions (I'd instead of I would) and informal vocabulary (find out instead of determine).

• Use a friendly and positive tone.

• Use words that are familiar to your intended audience. Shorter words tend to be more common, and they are generally preferable. For example, use doctor instead of physician. Pay back instead of reimburse. Can get instead of eligible. There are exceptions. For example, access is a short word, but it is health care jargon that is hard

for many consumers to understand. Organization is a five-syllable word, but is probably familiar to most readers.

• When a term is best known to your intended audience by its acronym, use the acronym and spell out the word that it represents in parenthesis with the letters that form the acronym in bold. For example: PCP (Primary Care Provider).

• Be on alert for words that are abstract or vague, or that may mean different things to different people. Replace these words with more specific words to be sure your readers understand the key messages.

• Keep your sentences simple and direct. Most should be reasonably short; about eight to ten words per sentence for most sentences. When sentences are long, the main point gets lost in all the words. Active voice makes the style more direct.

• Vary the length of your sentences. Somewhat longer, natural-sounding sentences of about 12 to 15 words can effectively break up the choppy effect of using many short sentences.

• Paragraphs should be relatively short. Short paragraphs are more inviting to your reader and give the visual appearance of being easier to read.

• Use simpler words rather than technical terms whenever you can without losing the content or distorting the meaning. Sometimes it's important to use a technical term, such as the words mammogram, or cholesterol.

• Appearance should be appealing at first glance. Pages should be uncluttered with generous margins and plenty of white space.

• The graphic design should use contrast, indentation, bullets, and other devices to signal the main points and make the text easier to skim.

• Use a large type and spacing between lines.

290.3.2 - Reading Levels

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Formulas are used to estimate reading level from the difficulty of the vocabulary and the sentences. While formulas are general indicators of the complexity of print materials, they shouldn't be the only indicator of difficulty. Contractors shall aim to get reading levels of letters as low as possible without losing important content or distorting the meaning and without sounding condescending to the reader. The target readability for decision letter is a 6th-9th grade reading level using one of the following formulas: Gunning Fog Index, Fry, SMOG, Flesh-Kincaid, or FOG.

Tips

• Formulas can produce choppy text that is actually harder to read. Don't try to make written material easier to read simply by shortening sentences and substituting shorter words for longer ones. You will end up with choppy text that is actually harder to read, despite an improved reading grade level score.

• Assume longer words are less familiar and harder to read than shorter ones, but note there are exceptions to this rule.

Use common terms where there are no alternatives. For example, for insurance industry terms or medical terms where there are no simple alternatives (e.g., hospital, mammogram, cholesterol, ambulance). Direct quotes from CMS policies can be excluded from reading level calculations as well as standard language provided by CMS, industry terms and medical terms where there are no alternatives.

290.4 - Required Elements in Appeals Correspondence

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following should be used in all appeals correspondence:

• The name of the beneficiary/provider/physician/supplier to whom the letter is addressed rather than "Dear Sir/Madam;"
• Correspondence is identified by either the date on written correspondence or the date the written correspondence was received;
• The name of the provider, physician or supplier as well as the date(s) of service;
• When appropriate, an explanation in letters to beneficiaries, explaining why he/she is being sent a letter if the appeal came from the provider, physician or other supplier;
• The appeal determination/decision is placed in the beginning of the letter;
• Explicit rationale that describes why the items or services at issue do not meet Medicare guidelines. Merely stating that an item or service is "not medically reasonable and necessary under §1862(a)(1)" or "not medically reasonable and necessary under Medicare guidelines" does not provide any rationale. The rationale should include a description of the logic that led to the decision, references to the support for the basis of the decision, and other information that is relevant to support the decision in the case;

• When the appeals correspondence includes Medicare statutory citations, they must be related to the decision in layman's terms. The statutory cite is listed as a parenthetical at the end of the sentence. For example, instead of beginning a sentence with, "§1879 of the Social Security Act states that...," the sentence should start with "Under Medicare law, suppliers must....(§1879 of the Social Security Act)";
• Whenever the person is to receive some further response, such as an MSN (if available), an estimated time frame as to when he/she will receive it is provided;
• Telephone number on all correspondence for additional questions;
• What, if anything, must be done next, and by whom;

• As appropriate, the results of any consultations with professional medical staff;
• When applicable, a statement advising the appellant that upon written request the contractor will provide them copies of regulations, statutes, and guidelines used in making the determination;
• For appeals, if the redetermination is partially or wholly favorable, an explanation about why the new determination is different from the previous determination; and
• The correspondence must be written in a clear manner and with a customer-friendly tone.

300 - Disclosure of Information

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

300.1 - General Information

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The basis for policy governing the disclosure and confidentiality of information collected by the contractor is §1106 of the Act, the Department's Public Information regulations, as well as the Privacy Act, and the Freedom of Information Act. In general, all information relating to an individual is confidential except as provided by regulation. In the interest of an appellant's right to due process, there are situations where information may be disclosed. The CMS regulations implementing §1106 of the Act can be found at 42 CFR Part 401, Subpart B. (See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.)

In addition, §1106 in title XI of the Act provides penalties for violation of the provisions concerning confidentiality of information. Activities prohibited under the provisions of the Act include, but are not limited to, making false and fraudulent statements, fraudulent concealment of evidence affecting payment benefits, false impersonation of another individual, misuse or conversion of payments for use of another, and improper disclosure of confidential information. (See the Medicare Program Integrity Manual.)

300.2 - Disclosure of Information to Third Parties

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If a beneficiary wishes to have his/her information disclosed to a third party without appointing that individual as a representative, this can be accomplished by the beneficiary or third party providing written authorization to the contractor for the release of the information. The written authorization must contain a signature of the beneficiary and an explanation of the type of information the beneficiary agrees to release to the individual. An example of this type of situation is where a beneficiary has asked a Member of Congress for assistance with his/her appeal. In this case, it may be necessary for the Member of Congress to receive the decision; however the Member of Congress does not wish to accept the responsibility associated with being the

beneficiary's appointed representative or the beneficiary does not wish to appoint the Member of Congress as his/her representative. See §310.1 for more information on requests for redetermination submitted by Members of Congress. If the beneficiary wishes to appoint a representative, contractors should refer to §270.

300.3 - Fraud and Abuse Investigations

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Any and all evidence used by the contractor to arrive at a determination or decision shall be placed in the appeals case file (copies are fine). Information in the case file shall be made available to an appellant upon request. Therefore, the contractor shall be aware that information placed in the case file is accessible to an appellant. The PSC shall also understand that the contractor may not consider any evidence that has not been made a part of the case file. The PSC and the contractor shall therefore exercise discretion when deciding whether to place any of the following information into the appeals case file:

- The impetus behind a fraud and abuse investigation;
- The name of the beneficiary or any other person lodging the complaint that triggers the fraud and abuse investigation;
- Notes or transcripts of beneficiary interviews resulting from a fraud and abuse investigation;
- Records or information compiled for law enforcement purposes during a fraud and abuse investigation; or
- The name of a confidential source(s) when confidentiality has been promised by CMS in return for cooperation in a fraud and abuse investigation.

Where the contractor relies upon any of the above information in order to deny a claim or to render a less than fully favorable determination or decision, then an appellant has a due process right to review this information. If information is kept out of an appeals case file for confidentiality reasons, it may not be relied upon to deny or reduce payment.

300.4 - Medical Consultants Used

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The parties are entitled to know the identity and qualifications of any consultant whose evidence the contractor used to support the initial claim determination or the redetermination. If the contractor uses a consultant, it shall include the identity and qualifications of the consultant in the file for possible use by the ALJ, and for the appellant's use upon request. This applies to both external medical consultants and internal staff used to review the claim. An example of this would be the name and title of the medical consultant.

300.5 - Multiple Beneficiaries

(Rev.1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If claims of more than one beneficiary are involved in the redetermination, and each beneficiary is being sent a copy of the decision, the contractor shall ensure the privacy of each beneficiary's records. The decision letter may be issued for each beneficiary, or the contractor may issue a basic decision letter, and include it with a cover letter to each beneficiary.