830.5 General

A beneficiary who believes that a decision on his claim for benefits is incorrect or who does not fully understand the notice should first seek assistance from the intermediary for Part A benefits, or the durable medical equipment regional carrier (DMERC) for durable medical equipment or Palmetto GBA for other Part B benefits. If a beneficiary contacts a field office regarding a Medicare payment after having contacted the intermediary, the DMERC or Palmetto GBA, attempt to answer his questions. Contact the intermediary or the DMERC or Palmetto GBA if necessary. If the beneficiary is still dissatisfied, he may request further consideration of his claim as explained in this chapter. RCM reference is 3.1.110 through 3.1.114.

If a beneficiary wishes to file for the reconsideration of benefits payable through an HMO/CMP, the field office should accept the written reconsideration request and send it directly to the HMO/CMP. RCM reference is 3.1.115.

Determinations involving eligibility for Medicare - Part A and Part B are considered initial decisions of the Office of Program - Operations and, as such, have the same reconsideration and appeal rights as retirement and survivor benefits under the Railroad Retirement Act. RCM reference is 3.2.140 and 3.2.141. Initial Medicare decisions include:

- Initial determinations of HI/SMI effective dates,
- Changes in HI/SMI effective dates,
- Denial of HI/SMI applications,
- Award of Canadian HI payments,
- Termination of HI/SMI coverage (except death and voluntary terminations).

830.10 Appeals Process - Part A or Part B Eligibility

When a person has questions concerning a Part A or B eligibility decision for coverage, attempt to explain the decision. If the person is not satisfied by the field office explanation, proceed as explained below. RCM reference is 3.2.140 and 3.2.141.

830.10.1 Request for Reconsideration

Secure a written request for reconsideration within 60 days of the notice of the decision when an individual wishes a review. The request should contain an explanation of why the person believes the decision to be incorrect. Forward requests for reconsideration to Assessment and Training (A&T) - Recon Section.

Note: The reconsideration and appeals wording normally used on initial decisions is not currently included on mechanically released Medicare enrollment packages. If a person requests reconsideration in this case, take his statement and send it to A&T - Recon Section A&T - Recon Section will determine if the request is timely.

830.10.2 Request for Appeal

A beneficiary who is not satisfied with a reconsideration decision may appeal to the Bureau of Hearings and Appeals (H&A) within 60 days of the reconsideration by filing Form HA-1. Form HA-1 is available in field offices. A completed Form HA-1 should be directed to H&A. If an individual is dissatisfied with the decision of an appeals referee in response to the filing of a Form HA-1, he may appeal to the three-member Board by filing a Form HA-2 within 60 days of the appeal referee's decision. Form HA-2 should be forwarded to the Office of the Secretary of the Board. For additional information about the appeals process, refer to FOM-1, Article 1.

830.15 Appeals Process - Part a Services

830.15.1 Services Furnished in Canada

Since Canadian claims under Part A are processed and paid by the RRB using funds from the RR account, Railroad Retirement Act appeals procedures apply. To initiate the process, a written statement requesting reconsideration must be submitted within 60 days of the decision notice to the beneficiary on the claim. Forward the statement to Assessment and Training (A&T) - Recon Section. The RCM reference is 3.2.140 and 3.2.141.

830.15.2 Services Furnished in U.S. or Mexico

The appeals procedure consists of three steps: reconsideration, hearing and a court review. The beneficiary must request each step within certain time limits and the amount in controversy must meet certain minimum dollar amount criteria.

A. **Reconsideration by Part A Intermediary (or HMO/CMP) -** A request for reconsideration must be made in writing within 60 days after receipt of the Notice of Utilization, the determination letter released by the intermediary directly to the beneficiary. The claim(s) in question can be for any amount. RCM reference is 3.1.113.

Requests for reconsideration of payment furnished by an HMO/CMP should be sent directly to the HMO/CMP. The RCM reference is 3.1.115.

Any inquiry received from a beneficiary must be stamped to show the receipt date to protect the filing date for reconsideration. A request for reconsideration should include the beneficiary's HI claim number, name, address, a brief reason for dissatisfaction and a copy of the Notice of Utilization. Indicate on the statement that it was prepared in the field office. Forward the request and a copy

of the Notice of Utilization to the intermediary whose address is shown on the Notice of Utilization. If the intermediary cannot be determined, secure the information from the nearest Social Security Administration (SSA) district office. **Do not** send the reconsideration request to A&T - Reconsideration Section.

If the complaint is received by telephone, advise the beneficiary to send a request for reconsideration to the intermediary. If the intermediary cannot be determined, advise the beneficiary to send a request for reconsideration to you. Upon receipt, contact the nearest SSA district office and determine where the request should be sent.

B. **Hearing** - If the beneficiary is dissatisfied with the results of the reconsideration, a hearing may be requested. The request must be made in writing within 60 days after receipt of the reconsideration notice and the amount in controversy must be at least $100.

If you receive an inquiry by telephone or in person and an SSA office is conveniently located, advise the beneficiary to contact the SSA district office. If the beneficiary will contact the SSA district office in person, (s)he should take the reconsideration notice along whenever possible.

If an SSA office is not convenient, or you receive a written inquiry, you may accept a request for a hearing. The request must include the beneficiary's HI claim number, name, address, brief reason for dissatisfaction and a copy of the reconsideration notice. Send the material to the SSA district office. Advise the beneficiary (s)he will receive notification from SSA.

C. **Court Review -** If the beneficiary is still dissatisfied after the hearing examiner's decision and the amount in controversy is at least $1,000, civil action may be initiated to request a judicial review with a U.S. District Court. The action must be initiated within 60 days after the mailing of the notice of the hearing decision.

830.20 Appeals Process - Part B Services

The appeals procedure consists of two steps: informal review and fair hearing. The beneficiary must request each step within certain time limits and meet a minimum dollar amount in controversy before a fair hearing can be held.

830.20.1 Informal Review

A request for a review must be made in writing within 6 months of the date of the "Explanation of Medicare Benefits" notice. The claims in question can be for any amount.

The beneficiary should complete Form G-790 (original only) or submit a statement with the same facts. If the beneficiary has additional evidence, it should be attached to the

Form G-790 or the statement. Send the request to Palmetto GBA or the durable medical equipment regional carrier (DMERC). The RCM reference is 3.1.114.

Requests for reconsideration of payment furnished by an HMO/CMP should be sent directly to the HMO/CMP. The RCM reference is 3.1.115.

A review of the entire claim will be done by someone who was not involved in the original decision. A letter will be sent to the beneficiary with an explanation and the result of the review.

830.20.2 Fair Hearing

If the beneficiary is dissatisfied with the results of the informal review, (s)he may request a Fair Hearing. The request must be made in writing within 6 months of the date of the letter notifying the beneficiary of the result of the informal review and the amount in controversy must be at least $100. The $100 may be accumulated during the last 6 months.

The beneficiary should complete Form G-791 (original only) or submit a statement with the same facts. A copy of the informal review should be attached as should any additional evidence. Send the request to Palmetto GBA or the DMERC that conducted the informal review.

Palmetto GBA or the DMERC will select a person to act as a hearing officer. The person is usually an attorney, but did not have had any previous involvement in the case. The hearing officer notifies the beneficiary of the time and place of the hearing, the specific issues to be resolved, the beneficiary's right to counsel or other representation, the right to bring witnesses, the importance of bringing all evidence and the necessity of promptly notifying the hearing officer in writing if the beneficiary has any objections. After the hearing, the hearing officer will make a decision and a copy will be mailed to the beneficiary.

If the beneficiary does not wish to appear or have a representative appear at the hearing, (s)he must waive this right in writing. The statement of waiver must be sent to the hearing officer. The hearing officer will then make a decision based on the evidence previously submitted. A copy of the decision will be mailed to the beneficiary.

830.20.3 Appeal with the Centers for Medicare & Medicaid Services (CMS)

The Omnibus Budget Reconciliation Act of 1986 expands Part B appeal rights for items or services furnished after January 1, 1987. A claimant must first invoke the established appeal procedures with Palmetto GBA or the DMERC, then they may proceed with the following:

- If Palmetto GBA or the DMERC maintains its original decision and the amount in controversy is $500.00 or more, claimants may request a hearing through CMS before an SSA Administrative Law Judge (ALJ).

- If the ALJ decision is unsatisfactory to the claimant, and the amount in controversy is at least $1,000.00, an appeal may be initiated in the Federal court system.

- Either dollar limit may be reached by combining two or more claims.

A request for an ALJ hearing can be made by submitting a written signed statement within 60 days of the date of receipt of the carrier hearing officer's decision. Requests for Part B ALJ hearings should be forwarded to:

Centers for Medicare & Medicaid Services
Medicare Hearing Work Group
P.O. Box 26683
Baltimore, MD 21207

The Centers for Medicare & Medicaid Services controls requests and forwards them to a designated ALJ through the SSA Office of Hearings and Appeals. Any subsequent development will be handled by the ALJ assigned to the case.