

Commercial Repayment Center (CRC) Non-Group Health Plan (NGHP) Applicable Plan Appeal Guide

*Your Guide to Submitting a Complete
Redetermination Request*

Steps in the Appeal Process

1. “Initial determination” (Medicare’s demand letter)
2. “Redetermination” by the contractor issuing the demand letter
3. “Reconsideration” by a CMS Qualified Independent Contractor (QIC)
4. “Hearing” by an Administrative Law Judge (ALJ)
5. “Review” by the Departmental Appeals Board’s Medicare Appeals Council (DAB MAC)
6. Judicial review

Standard Appeal Requirements

A request for a redetermination must be submitted no later than 120 days from the date of receipt of Medicare's demand letter (assumed to be five days after the demand date unless there is evidence to the contrary). Depending upon the basis of the appeal, there may be specific information and documentation that must be provided to sustain the appeal request. Note: This information must be provided on company letterhead or otherwise indicate its source.

Generally, the following documentation must be submitted by the applicable plan (or authorized recovery agent) for any level of appeal along with an explanation of why the demand (also known as the initial determination) is incorrect.

- Must provide the name of the party, or authorized representative of the party.
- Name of Beneficiary
- Medicare Number
- Date of Incident (DOI)
- Summary of injuries from the incident-specific service(s) and/or item(s) for which a redetermination is being requested
- Specific date of service(s)
- An explanation of why the applicable plan or authorized recovery agent disagrees with Medicare's initial determination

Reminder: Authorization/Letter of Authority Requirement

- An authorization (typically the Letter of Authority, or LOA) must either already be on file or submitted simultaneously with the redetermination request if the identified debtor wishes to be represented by another party in resolving the demand.
- Appeal requests from any entity that is either not the identified debtor (the applicable plan) or an authorized representative will be dismissed. An authorization may be submitted with a request to vacate the dismissal, but delays in receiving an appeal request from a duly authorized entity mean that the identified debtor runs the risk of their appeal request being dismissed for not being submitted promptly.
- Be sure to review model language for authorizations and include a cover letter or other identifying information to link your authorization to a recovery case.
<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery>

What Is and Is Not Subject to Appeal?

By regulation, the applicable plan may only appeal the amount and/or the existence of the debt. Any appeal with any other basis will be dismissed.

Appeals of the amount and/ or existence of the debt may be based upon one or more of the following situations:

[Termination of Ongoing Responsibility for Medicals \(ORM\) Due to Benefits Exhaustion](#)

[Termination of ORM Due to Settlement or Other Claim Resolution](#)

[Benefits Denied/ Revoked by Applicable Plan](#)

[Non-Covered Services](#)

[Unrelated Services](#)

[Duplicate Primary Payment](#)

[Termination of ORM Due to Other Policy Terms](#)

Termination of Ongoing Responsibility for Medicals (ORM) Due to Benefits Exhaustion

Situation:

The applicable plan asserts that it does not have primary payment responsibility for some, or all the dates of service included in the demand on the basis that the no-fault policy limit has been reached and benefits exhausted as outlined in the policy or plan.

Required Information:

- A cover letter that contains all required as outlined in the [Standard Appeal Requirements](#) slide.
- Payment ledger that demonstrates benefits were appropriately exhausted that accumulates to the reported policy limit (appropriate exhaustion means payment for specific services rendered by physician, facility, or beneficiary).

The documentation must contain the following:

- Date(s) of service
- The total amount of claim(s) billed
- Amount paid to Provider
- Provider name
- Name of recipient of processed claim or payment (For example, if reimbursement was made to the beneficiary for out-of-pocket payment)
- Date payment was processed and/ or issue

Notice:

- Payments to physicians, providers, suppliers, or beneficiaries made after receiving Medicare's demand letter do not excuse the applicable plan in lieu of reimbursing Medicare.
- The CRC also requires a declaration page that documents the plan's no-fault policy limits. If the policy limit asserted in the appeal differs from the reported SEC111 policy limit.
- Applicable plans must combine MedPay and PIP limits for a given policy and ORM must be maintained until both the PIP and MedPay benefits are exhausted.

Termination of ORM Due to Settlement or Other Claim Resolution

Situation:

The applicable plan asserts it does not have primary payment responsibility for some or all the dates of services included in the demand letter as ORM has terminated due to a settlement, judgment, or award. Generally, Medicare claims with dates of service between the ORM effective and termination dates are the responsibility of the CRC to recover from the applicable plan.

Required:

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- A copy of the complete settlement documentation along with signatures and effective dates.

Note:

- If ORM has terminated due to benefits exhausted, please follow the guidelines for “ORM Termination Due to Benefits Exhausted,” as discussed in the previous slide.
- If ORM has terminated due to a policy being terminated or lapsed, please provide supporting documentation that outlines policy effective dates on the applicable plan’s or authorized recovery agent’s letterhead.

Benefits Denied/Revoked

Situation:

The applicable plan asserts that it does not have primary payment responsibility because the Worker's Compensation or No-Fault claim was denied or benefits were revoked; based on injury incurring health costs that occurred during (or after) a violation of coverage policy, or State or Federal law.

Documentation Needed:

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- Proper documentation must demonstrate and document that the benefits for the claim were denied/revoked for the DOI in question.
 - Copy of decision letter from the applicable plan to the beneficiary, specific to the DOI, indicating the reason why the claim was denied, or benefits were revoked

Reminder:

If a Workers' Compensation or No-Fault claim is denied by the applicable plan in its entirety, or benefits revoked effective upon a specific date, the applicable plan should ensure any information reported through Section 111 reporting is updated (or deleted) immediately.

Non-Covered Services

Situation:

The applicable plan asserts any of the following:

- The beneficiary did not submit the required documentation to the applicable plan needed to process or pay claims for the incident
- Service(s) or service provider was not approved or licensed by the state
- Service(s) required prior-authorization
- Service(s) were not covered by the plan

Documentation Needed:

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- Proper documentation specific to the DOI in question, that must demonstrate that the services were not covered. Copy of plan documents or policy, indicating what services are not covered or what requirements exist for the policy.
- A payment ledger showing that the date(s) of service were denied. The payment ledger should contain:
 - Date(s) of service
 - Total amount of claim(s) billed
 - Provider Name
 - Date processed/payment was denied
 - Denial code/reason stating services were not covered

Unrelated Services

Situation:

This appeal can be used by the applicable plan and/or authorized recovery agent when one or more specific claims for service(s) or treatment are for a condition unrelated to the accident, date of loss, or incident.

Documentation Needed

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- Copy of Medicare's annotated payment summary form or an attestation on an applicable plan's or authorized recovery agent's letterhead outlining why specific service(s)/diagnosis code(s) are determined to be unrelated.

Duplicate Primary Payment

Situation:

When Medicare and an applicable plan both make primary payment for the same date of service(s) listed on a Medicare demand, the applicable plan or authorized recovery agent may provide proof of their primary payment as an appeal.

Documentation Needed:

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- Proper documentation, such as a payment ledger form, that must clearly outline the information below:
 - Date(s) of service
 - Total amount of claim(s) billed
 - Amount previously paid to Provider
 - Date processed/payment was made
 - Name of recipient of processed claim or payment

Reminder: The applicable plan or authorized recovery agent may not make primary payment to the Provider/Supplier/Beneficiary after receiving a Medicare demand letter in lieu of paying the Medicare demand.

Termination of ORM Due to Other Policy Terms

Situation:

The applicable plan asserts that the terms of the policy and/or plan may allow the applicable plan to terminate coverage. A plan may determine assessments such as a physician's examination to determine situations where the applicable plan has no additional payment responsibility.

Note that this does not negate the applicable plan's primary payment responsibility should other terms, laws, or regulations require primary payment responsibility to continue (for example, state law mandates medical coverage for five years past the date of incident).

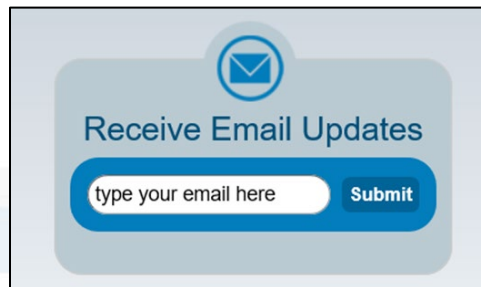
Documentation Needed:

- Cover letter that contains all required elements as outlined in the [Standard Appeal Requirements](#) slide.
- Supporting documentation that demonstrates the circumstances that have been met to allow termination of coverage, as well as a copy of any other policy or plan documents that establish the applicable policy terms that permit ending the applicable plan's primary payment responsibility.

Reminder: The applicable plan should ensure any information reported through Section 111 reporting is updated as soon as possible in the event ORM has terminated.

Additional Resources

- Existing appeals documentation is available on the Insurer Services section of CMS.gov. <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/InsurerServices/Insurer-NGHP-Recovery>
- Any questions that we were unable to get to during the Q&A session can be submitted to the NGHP mailbox at COBR-NGHP-Comments@cms.hhs.gov.
- The CRC can be reached at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).
- You can also sign up for email alerts on CMS.gov to be notified when new content is added. Just enter your email in the “Receive Email Updates” box at the bottom of any CMS.gov page and select which pages or topics you wish to be notified about.



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