- The carrier must attempt to resolve as many issues as possible during the telephone conversation. Some telephone reviews may not be processed or completed because of the complexity of issues, need for additional documentation, or other factors. At the end of each telephone review, the carrier must advise the appellant of further appeal rights.
- The carrier must give the appellant a written determination advising him or her of the results of the review, regardless of whether a review is requested by telephone, in writing, or via electronic transmission.

C. Electronic Requests for Review

Filing review requests electronically would be easier and faster for parties than submitting a letter or the HCFA–1964 form (Request for Review of Part B Medicare Claim). Electronic requests would shorten the mailing time for submitting review requests and eliminate the paper hassle of hardcopy requests. Currently, not all of the carriers have the capacity to receive electronic requests for review. However, in the future all carriers will have the capability to accept electronic requests for review from entities that submit their claims electronically. We propose to provide for electronic requests for review but to limit this process to those entities that electronically bill their claims to a carrier system that has the capability to receive electronic requests for review. We would instruct carriers to inform their billers whenever they obtain this capability and inform them how the process works.

The following steps show how the electronic process is expected to work:

- Once the biller electronically receives notification of the initial claim determination from the carrier, he or she must enter a ''specified code'' to indicate that the retransmission is a request for review.
- For each line of the claim being submitted for review, the biller must indicate the reason for the review in the ''Notes'' field. This request for review is transmitted to the carrier.
- Any additional documentation the biller wants to submit can be mailed, or with carrier agreement, faxed to the carrier.

An appellant would have a 180-day period to request a review of an initial determination by electronic means, which is the same time allowed to file a written request for review. The appellant submitting an electronic request for review would receive an online acknowledgement at the time of transmission. Therefore, the appellant would have documentation that a request for review was filed and the time of filing. Since the appellant who submitted an electronic request would have more control over initiating the request for review than an appellant who telephoned for a request, we are not limiting electronic requests to 150 days.

The above explanation is being furnished simply to provide an idea of the way the process should work. However, should this proposed rule be finally implemented, the above process is not necessarily the exact process that will be employed.

III. Reasons for the Revisions

Parties to a Part B determination, particularly physicians who take assignment, often contact carriers by telephone to dispute a determination that a service was not covered or to obtain information about why they were paid less than they thought was reasonable. Sometimes, physicians call because they believe the code assigned to the service is incorrect, or they want to correct some other error they believe the carrier made.

Many beneficiaries raise questions about initial determinations if a denial or partial denial of a bill is involved. Beneficiaries often want to know why charges were reduced, especially if they believe the charges were reasonable.

As a result of these calls, carriers frequently make corrections by telephone, calling the process a reopening, informal review, or other name. This action requires administrative funds, even though the party has not actually used the administrative review process. The carrier, in effect, may do two reviews in place of one for each instance in which the informal action does not satisfy the party.

A party that calls to inquire about the initial determination, we believe, would be pleased to know he or she has the option of writing or calling to request a review. Whenever possible, the carrier would attempt to resolve issues during a call and provide a review determination at the conclusion of the call. At the end of each telephone review, the carrier would advise the party of further appeal rights.

The current review process that requires a party to write to request a review takes time and effort, especially for beneficiaries. At times, the party requesting a review in writing may have to wait approximately 45 days to receive a review determination. Our intention in encouraging telephone requests for reviews is to foster quick communication between the review staff and the parties. The proposed additional means of requesting a review by telephone or electronic transmission would improve customer service in the following ways:

- Making access to the appeals process easier.
- Saving time.
- Providing a more prompt response.
- Reducing paperwork. (Currently a party must write a letter or complete HCFA Form 1964 (Request for Review) or submit a completed EOMB to request a review.)
- Ensuring prompt payments.
- Improving our relationship with the beneficiary and physician/supplier communities.

IV. Exclusions From Telephone and Electronic Reviews

We do not intend to provide for telephone requests for review on Part B determinations made by Peer Review Organizations (PROs) because of the types of issues PROs handle. The issues are usually medically focused and highly technical. We also believe this process would not be administratively efficient and reasonable, if, in most cases, adjudication cannot occur at the time of the call. The process could actually result in delays and/or duplication of effort. We believe the issues and documentation needed to process PRO appeals are sufficiently different from other Part B reviews and the telephone request process would be cumbersome for these appeals.

Similarly, we do not intend to provide for telephone requests for review on Part B initial determinations made by Health Maintenance Organizations (HMOs). Requests for reconsideration of initial determinations made by HMOs are governed exclusively by 42 CFR part 417, subpart Q. Unlike part 473, subpart B (PRO reconsiderations and appeals process), there is no cross-reference to part 405, subpart H in part 417, subpart Q.

Electronic requests for review would be available to those billers that bill their claims to a carrier system that has the capability to receive electronic requests for review. Although PROs may make the review determination, it is the carrier or fiscal intermediary's responsibility to process any adjustments to the claim, as a result of the review determination. Since the PROs are not involved in the billing process, the PROs would not need to have the capability to receive claims and/or electronic requests for reviews.

V. Provisions of the Proposed Regulation

Under sections 205(a), 1102(a), 1871(a)(1) and 1872 of the Act, the