

Medicare Denials and Appeals

From time to time, Medicare will deny a claim. These denials are counted as errors. They also give you a clear indication of the accuracy of your Medicare procedures. Appeal **ALL** denials.

Step One: The Telephone Reopening:

- “Minor errors or omissions in an initial determination may be corrected only through the contractor’s reopening process. Since it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings.
- In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for a reopening.”¹
- Reopenings are a discretionary action on the part of the contractor. A contractor’s decision to reopen a claim determination is not an initial determination and is therefore not appealable.
- Requesting a reopening does not toll the timeframe to request an appeal.
- Reopenings are separate and distinct from the appeals process.

Medicare Appeals

There are five levels of appeal

- Redetermination
- Reconsideration
- Administrative Law Judge (ALJ) Hearing
- Departmental Appeals Board (DAB) Review
- Federal Court Review

Collections

- Medicare has changed the rules regarding collection of overpayments.
- Even though some levels of appeal have up to a 180 day limit for filing, Medicare will start collection actions after 30 days.
- An appeal will delay a collection action.
- Start your appeal as soon as possible.

Who Can File An Appeal

- According to the Medicare Benefits Policy Manual, Chapter 29, Section 210, the following person or entity has appeal rights.
- The beneficiary.
- A participating supplier. (a physician is defined as a supplier) Non-participating suppliers accepting assignment of a claim for items or services (but only for the items or services which they have billed on an assigned basis). A non-participating physician not billing on an assigned basis but who may be responsible for making

¹ Medicare Claims Processing Manual, Chapter 29, Section 200(D)

a refund to the beneficiary under §1842(l)(1) of the Act for services furnished to a beneficiary that are denied on the basis of section 1862(a)(1) of the Act, has party status with respect to the claim at issue. A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal. See §210.1 for information on determining whether there is another party available to appeal.

- Neither the contractor nor CMS is considered a party to an appeal at the redetermination or reconsideration levels, and therefore does not have the right to appeal or to participate as a party at this stage in the administrative appeals process. If you are a non-participating who has not collected from the patient then you need to get an Assignment of Appeal Rights.

Assignment of Appeal Rights

- 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.
- You must use form CMS-20031

Redetermination

- “A redetermination is the first level of appeal and is a second look at the claim and supporting documentation and is made by a different employee.”²
- “The time limit for filing a request for redetermination is 120 days from the date of receipt of the notice of initial determination. The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary.”³
- “There is no minimum monetary threshold to be met for filing a redetermination.”⁴
- This is the level where you present supporting documentation. Appeal requests submitted electronically via a facsimile or secure Internet portal/application shall be considered to have been received in writing.
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- Use Form CMS 20027 to file a request for redetermination. This form is located at; <http://www.cms.hhs.gov/CMSForms/>. Click on “CMS Forms” at the left of the page.
- The reason that you do not agree with the determination should be that; “The services were medically necessary.”
- Your relationship to the beneficiary is “Provider”.
- Attach supporting documentation at this time.
- Supporting documentation should include: History, initial exam, re-exam, treatment plan, and outcome assessment forms from before and after the disputed date(s) of service.
- The decision must be rendered and mailed within 60 days.
- Unfavorable and partially favorable results will be sent by mail.

² Medicare Claims Processing Manual, Chapter 29, Section 310

³ Medicare Claims Processing Manual, Chapter 29, Section 240

⁴ Medicare Claims Processing Manual, Chapter 29, Section 220, Chart 1

- Favorable results will usually be reported in the Remittance Advice (RA) or Medicare Summary Notice (MSN).

Reconsideration

- The reconsideration is the next level of appeal if your redetermination is not in your favor.
- The request for reconsideration must be filed with the Qualified Independent Contractor (QIC) specified on the redetermination notice.
- The request for reconsideration must be made within 180 days of receipt of the redetermination.
- There is no minimum monetary threshold to be met for a reconsideration.
- Use the form CMS20033 to file a request for reconsideration. This form is located at; <http://www.cms.hhs.gov/CMSForms/>. Click on “CMS Forms” at the left of the page.
- Your reason should be the same as for the redetermination.
- If you have any additional information to send, send it now. This is your last chance.
- The QIC will request the file from the contractor and it should have everything that was used for the redetermination.
- The QIC has 60 days to process the reconsideration and render a decision.
- If the reconsideration is favorable, you will receive payment within 30 to 60 calendar days.

Administrative Law Judge (ALJ) Hearing

- A hearing before an Administrative law Judge (ALJ) is your next level of appeal.
- “To receive an ALJ hearing, a party to the QIC’s reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC’s reconsideration.”
- The request must be filed within 60 days of receipt of notice of the QIC’s reconsideration and the amount in controversy must be \$140 or more.
- A key point to remember here is that you (the doctor) are the appellant if you started the appeal and took the case through the two previous steps.
- Use the form CMS20034 for the ALJ appeal. This form is located at; <http://www.cms.hhs.gov/CMSForms/>. Click on “CMS Forms” at the left of the page.
- Copies of this completed form need to go to all parties.
- You (the doctor) are the appellant.
- Your information (but not your name) is placed under the section marked “Provider”.
- The beneficiary’s name and address is placed in the section marked “Beneficiary”.
- You can choose to have a hearing (which you must attend) or have a decision based on the evidence in the case.

- You may attach additional evidence but you need a very good reason why you are just now presenting it.
- Sign the form as the appellant.
- Questions A and B are answered as appropriate. You may appeal multiple claims and/or beneficiaries at this level.
- Question C is “no” as you are the appellant.
- The last two sections are not completed, as you are not representing the beneficiary.
- Attach a copy of the reconsideration determination.
- Steps in the hearing process.
- Before the hearing.
 - You and your representative, if you have one, may look at the evidence in your case file and under certain circumstances, you may be able to submit new evidence.
 - **It is very important that you submit any new evidence within 10 days of receiving the Notice of Hearing.**At the hearing.
 - The ALJ explains the issues in your case and may question you and any witnesses you bring to the hearing.
 - The ALJ may ask other witnesses, such as a doctor or other experts, to come to the hearing.
 - You and the witnesses answer questions under oath. The hearing is informal, but we do make audio recordings.After the hearing.
 - The ALJ issues a written decision after considering all the evidence.
 - The ALJ sends you and your representative, if you have one, a copy of the decision.This will give you an overview of information on the ALJ review.
- For additional information go to: <http://www.hhs.gov/omha/needtoknow.html>.

Departmental Appeals Board (DAB) Review

- The next level of appeal is to the Departmental Appeals Board (DAB).
- You have 60 days from the date of receipt of the ALJ hearing decision.
- There is no minimum dollar amount required for a DAB review.
- There is no form for filing this level of review.
- Requests for review must be made to the DAB or the ALJ Hearing Office.

Federal Court Review

- This is the last level of appeal.
- You have 60 days from receipt of DAB decision or declination of review by the DAB to file with the US District Court.
- The amount in controversy must be at least \$1,400.⁵

⁵ All information was obtained from Medicare Claims Processing Manual, Chapter 29

CHART 2 - Where to File and Appeal

LEVEL	WHERE TO FILE AN APPEAL	
	Part A*	Part B
Redetermination	FI	Carrier
Reconsideration	QIC	QIC
ALJ Hearing	FI or HHS OMHA Field Office if heard by a QIC	Carrier or HHS OMHA Field Office if heard by a QIC
DAB Review	DAB or ALJ Hearing Office	DAB or ALJ Hearing Office

*Includes part B claims filed with the FI.

CHART 1 - The Medicare Fee-for-Service Appeals Process

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	At least \$100 remains in controversy.* For requests filed on or after January 1, 2006, at least \$110 remains in controversy.
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of DAB decision or declination of review by DAB	At least \$1,050 remains in controversy.* For requests filed on or after January 1, 2006, at least \$1,090 remains in controversy.

* Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

Lawyer

- The level at which you choose to bring a lawyer into this process is completely up to you.
- The first two levels are designed to be handled by the provider or the beneficiary.

Appointing a Representative

- A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the contractor.
- A representative may be appointed at any point in the appeals process.
- The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative. New appeals may be initiated by the representative within the 1-year timeframe.
- You can use form CMS-1696 to appoint a representative.
- 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.

Clinical review Judgment

- On June 15, 2010 CMS implemented the Clinical Review Judgment effective for MACs, RACs, CERT, PSCs and ZPICs.
- The Clinical Review Judgment has two steps:
 - The synthesis of all submitted medical record information (e.g., progress notes, diagnostic findings, medications, nursing notes) to create a longitudinal clinical picture of the patient.
 - The application of this clinical picture to the review criteria to make a reviewer determination on whether the clinical requirements in the relevant policy have been met.
- The Clinical Review Judgment process is to be used when making complex medical review determinations about a claim.
- The purpose of this change is to better “standardize” the review process. This gives us another tool to help the doctor survive a review.
- The doctor can now submit the additional documentation necessary to develop a complete picture of the patients’ condition and it **must** be considered.
- You can find the regulation here:
<http://www.cms.gov/manuals/downloads/pim83c03.pdf>.