

# Summit Medicare Documentation Article VI

## THE MEDICARE APPEALS PROCESS

### Introduction

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Getting paid for what you do sometimes involves appealing claim denials. In the case of Medicare, the government maintains specific protocols for the appeals process. The following outline will assist you in knowing what is required to appeal a Medicare denial.

*NOTE: The Summit recommends and encourages DCs to appeal ALL improperly denied claims (even if it is only one claim); historically, many DCs do not. Remember that appealing is not only a service to your patient, who has a right to have their payable covered services reimbursed, but also is a service to your profession.*

### Overview

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- When an initial claim determination is made, and the claim is denied, participating physicians have the right to appeal.
- Physicians who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians who did not accept assignment (and therefore do not have appeal rights). Form CMS-20031 must be completed and signed by the beneficiary and the non-participating physician to transfer the beneficiary's appeal rights.
- All appeal requests must be made in writing.

Medicare offers five levels in the Part B appeals process. The levels, listed in order, are:

1. **Redetermination** (performed by the carrier/MAC);
2. **Reconsideration** (performed by a Qualified Independent Contractor);
3. **Hearing** (performed by an Administrative Law Judge);
4. **Review** (performed by the Medicare Appeals Council (within the Departmental Appeals Board); and
5. **Judicial Review** (in U.S. District Court).

### The First Level of Appeal: Redetermination

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A redetermination is the examination of a claim by carrier/MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

## Requesting a Redetermination

A request for a redetermination may be filed on Form CMS-20027 available at <http://www.cms.gov/cmsforms/downloads/cms20027.pdf>. In addition, a contractor-specific version can usually be found on the contractor's web site.

A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should include supporting documentation with their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination/denial.

## The Second Level of Appeal: Reconsideration

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If dissatisfied with the outcome of the redetermination, a reconsideration may be requested. A QIC (Qualified Independent Contractor) will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

## Requesting a Reconsideration

A written reconsideration request must be filed within 180 days of the redetermination. To request a reconsideration, follow the instructions on the Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033, which can be found here:

<http://www.cms.gov/cmsforms/downloads/cms20033.pdf>. Again, a contractor-specific version can usually be found on the contractor's web site.

If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service

- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the redetermination

The request for reconsideration should clearly explain why you disagree with the redetermination. A copy of the MRN, and any additional documentation you feel may be useful, should be sent with the reconsideration request to the QIC identified in the MRN.

Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing, and any other evidence relevant to the appeal, must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

### **Reconsideration Decision Notification**

Reconsiderations are conducted “on-the-record” (based on the information submitted) and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request. The decision will contain detailed information on further appeals rights, if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an Administrative Law Judge.

### **The Third Level of Appeal and Beyond**

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Our next article will focus on the last three levels of appeal, with a focus on what is perhaps the most significant level, the Administrative Law Judge (ALJ), Level 3. Historically, the ALJ level has proven to be the most favorable level for providers (although the vast majority have been won prior to reaching this level).

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*For further information on these subjects and others, please refer to the sources for this article which include: CMS publications, the CMS manual system, and the ACA web site (<http://www.acatoday.org/medicare>).*

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The members of the Summit Subcommittee on Documentation are Dr. Carl Cleveland III, Dr. Farrel Grossman, Dr. John Maltby, Dr. Peter Martin, Ms. Susan McClelland, Dr. Ritch Miller, Dr. Frank Nicchi, Mr. David O’Byron and Dr. Frank Zolli. Dr. Miller served as principal author of this article with contributions from members of the subcommittee and documentation working group.