

## Timely Topics

### PAYMENT AND PRACTICE MANAGEMENT

April 2016

#### Medicare Appeals Process

There has been some new and significant information regarding [Overpayments](#) from Medicare, but what should be done when an underpayment is identified? This Timely Topic offers a review of your options in pursuing correct payment.

##### Identifying Underpayments

An underpayment includes any claim that has been processed without allowing full payment according to the Medicare fee schedule for a medically necessary service allowable per the covered benefits.

Prior to requesting an appeal or redetermination, first confirm if the denial is due to a minor error or omission. Examples of minor errors or omissions may include:

- Data entry mistakes
- Incorrect procedure or diagnosis codes
- Incorrect fee schedule applied at adjudication
- Duplicate claim denials for claims that should not be considered duplicates
- Incorrect claim fields such as units, modifiers or dates of service
- Unprocessable/returned claims (remark code CO-16)(in this case submit a corrected claim)

##### Reopening a Claim

If a claim was denied or underpaid due to a minor error or omission, you may request that your Medicare Administrative Carrier (MAC) reopen the claim. This request may be submitted either by telephone or in writing. You will need to include information found on the original claim form, information found on the Remittance Advice (RA) and information as to the claim correction(s) needed. The request to reopen a claim cannot be submitted until an RA has been issued. The timeline to reopen a claim is up to one year from the date on the RA. The RA includes instructions on how to request reopening of your claim(s).

Not all claims are eligible to be reopened. Examples of claims that cannot be reopened are:

- Claims denied for untimely filing
- Changes to the following modifiers—
  - GA - You have provided an Advance Beneficiary Notice (ABN) to the patient,
  - GY - The service is statutorily excluded from the Medicare Program), and/or
  - GZ - You expect a medical necessity denial but did not give an ABN to the patient
- Requests for redeterminations
- Any claim the Medicare Administrative Contractor (MAC) determines is too complex for reopening and/or may need additional research or documentation
- Claims for which a reopening was previously requested

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These types of issues would require filing an appeal with your MAC for consideration of possible payment.

#### The Appeals Process

The next option in pursuing payment on a claim is to start an appeal. There are five levels of the appeals process:

1. Redetermination by your MAC
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearing before an Administrative Law Judge (ALJ)
4. Review by the Medicare Appeals Council (appeals council)
5. Judicial review in the US District Court

Each level of the appeals process must be requested in writing. The first-level appeal is a redetermination. A redetermination request must be submitted to your MAC within 120 days of receipt of the RA. Redetermination requests do not require a minimum claim Amount in Controversy (AIC). To request a redetermination submit the information as outlined on [Form CMS-20027](#). The request should include all specific information you would like the MAC to consider when reviewing the claim for additional payment.

Reconsiderations or second-level appeals must be filed within 180 days of receipt of the redetermination. The written request should include all information as outlined on Form [CMS-20033](#) and should be accompanied by any documentation needed to support the request. Any documentation identified as deficient in the redetermination may also be included. The QIC will review all the information in your case file regarding the original adjudication as well as the redetermination. Typically the QIC will respond with its decision to all parties within 60 days of the request.

If the reconsideration is not fully favorable, the notice will include information for further appeal rights. As of 2016 the minimum AIC threshold to request the third-level appeal is \$150. If this threshold is met, you can request a hearing by an Administrative Law Judge (ALJ) by submitting your request on the appropriate form. This request must be done within 60 days of the reconsideration. The QIC's reconsideration determination will include information needed to submit the next level of appeal.

A fourth-level appeal is a request to the Medicare Appeals Council to review the ALJ's decision. It must be submitted on the appropriate form to the Appeals Council within 60 days of receiving the ALJ's decision. As with each previous level, a statement explaining why you disagree with previous decision and any additional documentation should be included. The Appeals Council will usually respond with its decision within 90 days.

The final or fifth-level appeal is to request judicial review by a federal district court. The minimum threshold of AIC is \$1,500, which can include one or more claims. The Appeals Council's decision notice will include all the information you need for this level of appeal.

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At each level in the appeals process you may request the appeal be escalated if not processed in a timely manner as long as the required minimum thresholds are met.

The above timelines are specific to the Appeals process for original (Part B) Medicare. The process and levels are the similar for Medicare Advantage products; however, the timeline between the initial determination and a request for reconsideration is only 60 days rather than 120 days. In addition, if the reconsideration upholds the denial the appeal will automatically be forwarded to the independent review examiner under contract with CMS for independent appeal decisions.

#### Summary

When considering whether to pursue additional payment be sure to:

- Review the remittance advice to confirm the reason for the denial.
- Review the original documentation in comparison to the claim coding for correct codes (procedure and diagnosis) and modifier usage.
- Review applicable posted edits such as National Correct Coding Initiative, Medically Unlikely Edits (MUE) and any applicable local or national coverage determinations. For more information on these edits, please see our [January 2016 Timely Topic](#)
- Confirm that the claim appropriately represents the service rendered.
- Confirm whether an appeal is necessary or if a reopening or corrected claim can be requested instead.

Once you identify an underpayment as per your contract and the patient's benefits, make sure to include all the requested documentation that supports your claim and to meet all the required timelines. Following these steps will improve the likelihood for a successful appeals process and/or for receiving additional payment when appropriate.

#### References

For additional information regarding the appeals process, review the following resources:

1. [Medicare Claims Processing Manual Chapter 29](#)
2. [Medicare Claims Processing Manual Chapter 34](#)
3. [Original Medicare Appeals](#)
4. [Medicare Health Plan Appeals](#)