This course is designed to provide Part A providers with an understanding of the Medicare Appeals process. At the end of this course, participants will be able to:

- Identify the five appeal levels.
- Submit an appeal request correctly.
- Locate educational resources and quick reference tools to assist you in submitting an appeal.
The Benefits Improvement and Protection Act of 2000 (BIPA) and the Social Security Act, Section 1869 (c) outlines the Administrative Appeals Process.

Additionally, Section 937 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires contractors to establish a process, effective January 1, 2006, for the correction of minor errors and omissions.

Providers may appeal processed claims where an initial determination has been made.

The claim may have been denied based on Medicare’s local or national coverage decisions, inappropriate coding of diagnoses and/or procedure codes, or other reasons.
CMS defines clerical errors as human or mechanical errors on the part of the party or the contractor, and may include mathematical or computational mistakes, transposed procedure or diagnostic codes, inaccurate data entry, computer errors and some duplicate denials which the party believes were incorrectly identified as a duplicate and incorrect data items, such as provider number, use of a modifier or date of service.

Clerical Error Reopening (CER)
The following issues **can** be addressed as a reopening:

- Number of units billed
- Adding a diagnosis code
- Changing a CPT code
- Changing a date of service
- Adding modifiers
- Changing billed amounts
- Cancel claim request

The following issues **cannot** be requested as a reopening:

- Any part of a denied line item on a partially paid claim
- Any part of a denied line item by Medical Review
- Ambulance services
- Medicare Secondary Payer (MSP) issues
- Issues where a Recovery Auditor (RAC) demand letter is involved
CER Request Form

• Complete thoroughly to expedite processing
• Be specific in request
• Circle changes on UB-04 or use * to note changes
• Signature required
• Do not mark or write on the barcode
Purpose of Appeals

• The purpose of the appeals process is to receive a new determination and independent review of the denied claim. This process utilizes the pertinent Medicare laws and rules, provider documentation, and patient record regarding the denied service.

• The appeals process gives dissatisfied providers and beneficiaries a vehicle to request an independent reevaluation of Medicare’s claim decision.

• Through this process, Medicare seeks to ensure that the correct payment is made or a clear and adequate explanation is given supporting nonpayment.
Parties to an Appeals

Parties to an appeal may include:

• the patient or patient advocate
• the participating provider or supplier
• the non-participating physician who has accepted assignment on a particular claim or whose service was denied due to medical necessity; denied due to medical necessity
• Medicaid, state agency or party acting on behalf of the state
• an individual whose rights with respect to the particular claim being reviewed may be affected by such review
• any other individual whose rights with respect to supplementary medical insurance benefits may be prejudiced by the decision (e.g., an individual or entity liable for payment under 42 CFR Subpart E 424.60 in the case of a deceased beneficiary)
Introduction of Medicare Appeals: Five Appeals Levels

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal any Medicare denial of coverage.

Medicare offers five levels of appeal. The levels, listed in order, are:

1. Redetermination
2. Reconsideration
   - Done by Qualified Independent Contractor (QIC)
3. Administrative Law Judge (ALJ) Hearing
4. Medicare Appeals Council Review
5. Final Judicial Review
## Appeals Levels for Fee-for-Service (FFS) Providers

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Requirements</th>
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<tbody>
<tr>
<td><strong>1st level</strong>&lt;br&gt;Redetermination</td>
<td></td>
<td>Must file within 120 days from the date of the initial determination notice on the Medicare remittance advice or Medicare Summary Notice (MSN).&lt;br&gt;No minimum Amount in Controversy (AIC)&lt;br&gt;Appeal processing time = 60 days from receipt date of request</td>
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<tr>
<td><strong>2nd level</strong>&lt;br&gt;Reconsideration</td>
<td></td>
<td>Must file within 180 days of the date of the redetermination notice&lt;br&gt;No minimum AIC&lt;br&gt;Appeal processing time = 60 days from the receipt date of request</td>
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<tr>
<td><strong>3rd level</strong>&lt;br&gt;ALJ Hearing</td>
<td></td>
<td>Must file within 60 days of receipt of reconsideration notice.&lt;br&gt;Minimum AIC required&lt;br&gt;Appeal processing time = 90 days from receipt date of request</td>
</tr>
<tr>
<td><strong>4th level</strong>&lt;br&gt;Appeals Council Review</td>
<td></td>
<td>Must file within 60 days of the date of the ALJ notice&lt;br&gt;No minimum AIC&lt;br&gt;Appeal processing time = 90 days from receipt date of request</td>
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<tr>
<td><strong>5th level</strong>&lt;br&gt;Final Judicial Review</td>
<td></td>
<td>Must file within 60 days of the date of the Appeals Council notice.&lt;br&gt;Minimum AIC required</td>
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A "Redetermination" is the first level of appeal, which is an independent, re-examination of the claim and its supporting documentation by Medicare staff who were not involved in the initial claim decision.

- Must be submitted in writing within 120 days from the receipt of the initial claim determination
- CMS-20027 Medicare Redetermination Request Form:
- No minimum amount in controversy required
- Submit supporting documentation to support the services
- The completed Redetermination Request form must include the *printed name* and *signature* of the representative submitting the Redetermination form and/or letter.
- Send to the appeals address found on the Cahaba Web site or form
A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A Qualified Independent Contractor (QIC) will conduct the reconsideration. The QIC will conduct an independent review of medical necessity by a panel of physicians or other health care professionals.

- Must be submitted to the QIC in writing within 180 days from the date of the notice of redetermination:
  - CMS-20033 Medicare Reconsideration Request Form:
  - A written request that includes the beneficiary’s name, health insurance claim number (HICN), specific service(s) and date(s) of service, name and signature of person requesting the appeal, and the name of the redetermination contractor.
  - Request should explain why you disagree with the redetermination. The QIC will request the appeals file from contractor.
  - Submit a copy of the Medicare Redetermination Notice (MRN) to the QIC.
  - No minimum amount in controversy required.
  - Send the reconsideration request to the QIC, which is identified in the Medicare Redetermination Notice (MRN).
Reconsiderations: Documentation

• Providers should submit all documentation with their reconsideration request. New medical record documentation submitted after the reconsideration request is filed, may extend the timeframe in which the QIC has to complete the decision.

• **Note:** No additional documentation can be submitted in subsequent levels of appeal unless good cause is shown.

• The QIC will send its decision to all parties within 60 days of receipt of the request.
• The contractor must effectuate the decision within 30 days of receipt of the QIC's decision.
• Mail Reconsideration requests to:
  
  QIC Part A East Project  
  MAXIMUS Federal Services, Inc.  
  QIC Part A East Project  
  1040 First Avenue - Suite 400  
  King of Prussia, PA 19406

• To check the status of a Reconsideration request, visit  
  [https://www.q2a.com/Appeals/CurrentAppealsStatus.aspx](https://www.q2a.com/Appeals/CurrentAppealsStatus.aspx)
If dissatisfied with the reconsideration decision and the amount in controversy (denied amount) is met, you have the right to a hearing by an ALJ. More than one beneficiary’s claim can be used to meet the amount in controversy.

- Must be submitted within 60 days from the date of the QICs decision to the entity specified in the QIC’s reconsideration decision


  - A written request that includes beneficiary’s name, address, and Medicare health insurance claim number, the name and address of the appellant, when the appellant is not the beneficiary, the name and address of the designated representative, if any, the document control number assigned to the appeal by the QIC, if any, and the reasons you disagree with the QIC’s reconsideration.

- ALJ will generally issue a decision within 90 days of receipt of the hearing request.
Fourth and Fifth Levels of Appeal

Appeals Council Review—Fourth Level of Appeal

If dissatisfied with the decision made by the Administrative Law Judge (ALJ), you may request a review from the Appeals Council.

- No minimum amount in controversy required.
- Send to the address included in your ALJ decision notice.
- File in writing within 60 days after the date of the ALJ’s decision notice.
- Refer to ALJ’s decision notice for details about filing a request for Appeals Council review.
- In general the Appeals Council will issue a decision within 90 Days of receipt of a request for review.

Final Judicial Review—Fifth Level of Appeal

- Refer to the Appeals Council’s decision for information about requesting a judicial review.
- The denied amount in controversy must be met.
- The request for Judicial Review must be filled within 60 days of receipt of the Appeals Council’s decision.
Appeals Resources: Centers for Medicare & Medicaid Services (CMS)

Centers for Medicare & Medicaid Services (CMS) Web site

Medicare Learning Network (MLN) The Medicare Appeals Process Brochure

MLN Special Edition Article SE0420: "MMA- Section 937 - Correction of Minor Errors and Omissions Without Appeals"

Claims Processing Manual (CMS Pub. 100-04, Ch. 29)

Education Material for this PowerPoint:
Click the link below and complete the Medicare Appeals Training Post-test:

http://w3.mccg.org/iota/test-medicare-appeals.asp

When the test is successfully completed, you will be prompted to enter information to record your results.