

Medicare Appeals

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Medicare appeals can seem daunting, but we hope that this guide will increase your understanding of the process, thereby improving your management of appeals. According to HCFA Federal government reports for the years 1999 and 2000, 30.3 percent of Medicare Part A denials were overturned on appeal, while 65.6 percent of Part B denials were reversed in favor of the appellant. Hence, your chances of appealing a denial are good, after you carefully deliberate on the amount on the denied claim versus the administrative costs and time your practice will incur in an appeal process. We urge you to use the ample resources on our website, www.entnet.org, to help streamline the process such as sample appeal letters, Medicare appeal forms, our policy statements, clinical indicators for various ENT procedures, our coding guidelines for ENT procedures, and other information.

You should review claims carefully prior to submission to ensure and reconcile billing codes, patient information, and medical documentation, as missing information is a recurring reason for denials. If you notice an increased frequency of denials, it would be germane to conduct a data analysis to investigate any incorrect billing processes in your practice; use the analysis as a training tool for staff.

Further, to reduce the incidence of denials and any additional administrative costs associated with appeals, you should verify the Medicare beneficiary's coverage by checking the National and/or Local Coverage Determination, prior to the date of service or by contacting your Medicare contractor. If it is plausible that Medicare will not cover the procedure, the patient should complete an Advance Beneficiary notice form (ABN). When Medicare denies a claim, there are five levels of appeal, as follows.

1) Redetermination

This is the first level of appeal after the Medicare contractor (fiscal intermediary, carrier, or Medicare Administrative contractor) offers an unfavorable initial determination. Providers have 120 days from the date the initial determination was received to file an appeal (CMS assumes it will take five days to receive U.S. mail). You can file the appeal on the CMS 20027 form, or if you are not able to fill out this form, CMS requires the following patient identifying information to accompany the request:

- The beneficiary's name
- Medicare health insurance number
- Specific item or services for which the redetermination is being requested
- Dates of service
- The name and signature of the beneficiary

Consequently, it is critical that you submit the request and supporting documentation simultaneously to avoid an automatic 14-day extension of the contractor's decision. The contractor has 60 days from the date of the receipt of the appeal to reverse or uphold its initial determination. The contractor will use the remittance advice notice (RA) and Medicare Summary Notice (MSN) to notify the provider and beneficiary of its decision and will disclose the coverage rationale used to make its decision, the clinical evidence used, and notice of the opportunity to appeal at a higher level.

If you are unable to meet the filing deadline, the contractor has the right to dismiss the appeal. To circumvent this, you will need to show (in writing) "good cause" explaining extenuating circumstances that led to the tardy submission. This should be accomplished within six months of receiving the dismissal notice from the contractor. Conditions to establish good cause include (but are not limited to):

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoid-

able circumstances encompass situations that are beyond the provider, physician, or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.

2) Reconsideration

If the contractor rules negatively concerning the redetermination, a Qualified Independent Contractor (QIC) will handle the next level of appeal. The QICs are divided by geographic region. Currently, there are five QICs—two for Part A, two for Part B, and one DME contractor. The QIC carries out an independent investigation and analysis of previously submitted documentation from the initial determination and the redetermination. National coverage determinations, CMS rulings, and applicable laws are binding on the QICs. They are not bound by "local coverage determinations, CMS program guidance, such as program memoranda, and manual instructions, but give substantial deference to these policies if they are applicable to a particular case." CMS requires the QIC to follow CMS regulations, except when an appellant proves reasonably to the QIC that an LCD or NCD does not apply to the coverage rationale. If the QIC agrees with the appellant's rationale, it must state the reason behind this decision.

If the redetermination was denied based on medical necessity, the QIC designates a panel of physicians or other appropriate healthcare professionals to review the case. If the claim involves physician services, the personnel who review the case must include a physician. Providers have 180 days to file reconsiderations from the date of receipt of the RA or Medicare Redetermination notice (MRN). You can file the reconsideration on the standard form CMS 20033; alternatively, you can send a written request, which must contain patient identifying information (same as preceding level), and the name of the contractor that made the redetermination. Any evidence that is not submitted by this level will be dismissed if introduced in subsequent levels without good cause.

If you are unable to meet the deadline for filing the reconsideration, as in the previous level, you must show

good cause for an extension in writing (see above). The QIC will make his/her decision on the reconsideration at least 60 days after receiving all the necessary information. If the QIC is unable to meet the decision deadline, CMS requires the contractor to contact the parties involved (in writing) explaining this inability and informing them of their rights to escalate the case to an Administrative Law Judge (ALJ). If the decision is not favorable, the QIC will inform the appellant of its decision and the next level of appeal, if the amount in controversy (AIC) for the denied claim is over \$120. According to CMS, “the AIC increased by the percentage increase in the medical care component of the consumer price index for all urban consumers. We will update our website annually with the AIC.”

3) Administrative Law Judge hearing

The appealing party has 60 days from receipt of the paper work from the QIC to file an appeal. ALJ hearings may be conducted in person, video teleconference (VTC), or by telephone. Multiple appellants can unite to meet the AIC requirements for an ALJ if the claims were previously reconsidered by a QIC.

A request for an ALJ hearing must be made in writing (you can use the standard CMS 20034 A/B form). If you do not use this form, you must send patient identifying information (same as earlier levels); the reason the appellant disagrees with the QIC’s reconsideration, and a statement of any additional evidence to be submitted.

The ALJ will send a notice providing details on the hearing and informing the appellants of their right to waive the hearing. If you have written evidence to submit to the ALJ, you will need to submit it within 10 days of receiving the notice of hearing; later submission may extend the time for the ALJ’s decision. Under certain extenuating circumstances (for example, if the appellant does not have a VTC), the ALJ can grant an in-person hearing. The office of Medicare Hearing and Appeals will make a coverage decision in 90 days. If the ALJ’s decision is unfavorable to the appellant, he or she can file another request for

appeal to the Medicare Appeals Council.

4) Medicare Appeals Council (MAC)

In this level, the appellant has 60 days to file an appeal, delineating specific reasons for contending with the ALJ’s decision. The appealing party can also escalate the case to a MAC if the ALJ is unable to make a decision in 90 days. In this case, the appellant must file the request for escalation to both the ALJ and the MAC. If this occurs, the MAC will review the case de novo (meaning the MAC will examine all issues and not just those appealed). The appellant will not have a right to a hearing by the MAC, which will review all the information in the administrative records and either reverse, adopt, modify the ALJ’s decision, or remand the case to the ALJ for further proceedings. There are no requirements for the AIC. If the MAC deems a negative decision, the appellant can move to the final level of appeal.

5) Judicial review in U.S. District Court

This level involves a judicial review in a Federal district court where the physician practice is located. A party should file its action to appeal within 60 days of receiving the denial from the MAC, and the case must meet the AIC requirement of being above \$1,180. There is no time limit for rendering a decision in this level. The standard review is substantial evidence.

Finally, we emphasize the importance of performing a cost-benefit analysis to ensure that it is worthwhile to apply your administrative and financial resources to appeal a case. Once you have determined this, we encourage you to use your right to appeal. For more appeal help and resources, visit our website: www.entnet.org/practice or call us at 1-703-535-3727.