

9. Rejections and Appeals

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9.1 Medicaid Appeal Process

Reasons for resubmitting or appealing Medicaid claims include

- Date of Service spans over the calendar year (payment and billed amount changes).
- The patient was admitted on September 13 and discharged on September 30, but Medicaid's eligibility was not effective until September 15.
- Eligibility information states the patient was not eligible for coverage; however, other information provided states the patient was covered.
- The initial claim was not received by Medicaid; however, the facility has proof of submission within the timely filing guidelines.
- The Authorization number was not on file.
- Medicaid has a record that the patient is covered by other insurance; however, research finds that the patient is not covered by other insurance.
- The Consent form was not present with initial bill.
- There was a coding discrepancy on the initial claim submission.
- There was a name discrepancy on the original claim.
- There were system errors.

Each state has its own appeal process. For guidance on the rejection and appeal process, contact your state Medicaid program.

Sample of the appeal and rejection process:

- Determine the validity of the denial or partial pay by reviewing the following items.
 - Date of Service
 - Type of Service
 - Medicaid Identification Number
 - Effective Date of Coverage
 - Review of Medical Record and PCC, PCC+, or Electronic Health Record
 - Diagnosis

- If denial of partial payment is invalid,
 - Resubmit a claim on the appropriate form.
 - Type a letter requesting reconsideration, stating a reason for the request.
 - Copy and attach one of the following documents:
 - Remittance Advice
 - Authorization Number
 - Consent Form
 - Proof of Medicaid Eligibility
 - Private Insurance denial EOB

9.1.1 Requesting a Hearing

A hearing process is available for any provider or facility who disagrees with decisions from Medicaid that relate to participation or termination from the plan, overpayment, or imposed sanctions. Most Medicaid state plans have 30 calendar days from the date of an action to request a hearing.

To be timely, the request must be received by Medicaid no later than the close of business of the specified day. Hearings are conducted and a written decision is issued to the provider within 120 calendar days from the date Medicaid receives the request, unless the parties agree to an extension.

For individual hearings, a pre-conference is usually scheduled to clarify the issues, resolve some or all of the issues, exchange documents and information, review audit findings, and discuss other matters.

Besides the traditional hearing, most state Medicaid programs offer either

- An expedited hearing for cases related to health, safety, or service availability; or
- A group hearing for cases where individual issues of fact are not disputed and where related issues of state and/or Federal law, regulation, or policy are the sole issues being raised.

Medicaid may deny or dismiss a request for a hearing when:

- The request is not received in a timely manner or within the time period stated in the notice
- The request is withdrawn, or canceled in writing by the provider

- The sole issue presented concerns a Federal or state law which requires an adjustment of compensation for all or certain classes of providers of services
- The provider fails to appear at a scheduled hearing without good cause
- The same issue has already been appealed or decided upon as to this provider and fact situation

Beyond the hearing process, if the final decision is upheld, providers still have the right to pursue judicial review of the decision. This must be accomplished within 30 calendar days from the date of the hearing decision

9.2 Private Insurance Appeal Process

To substantiate any denied claims through an appeal process, it is essential that you keep written records of all verbal and written correspondence at all levels of the patient encounter. This is especially critical in the issuing of prior approvals/authorizations by third-party payers.

Oftentimes claims are denied months or even years after the original submission. Because of this wide disparity in claims adjudication, document your correspondence in the **RPMS Accounts Receivable** messaging fields.

Documentation of conversations with payers should include at a minimum:

- Date the conversation took place
- Telephone number and extension of representative you called
- Person you spoke to
- Prior authorization or treatment numbers
- The name of the IHS facility staff person

In addition, be sure to note any additional information from the preauthorization telephone call or conversation. This can be found on page 5 of the RPMS registration editor. This can include comments such as “this individual was just added to the contract”. Written documentation of comments such as these can often be the deciding factor between a successful appeal and a denial.

Immediately after you receive the claim denial, begin the appeal process. If you believe you have a compelling rationale for an appeal resulting in the denial being reversed, proceed with that appeal.

Each appeal letter does not have to be customized. Craft a letter that has worked in the past. Keep copies of prior letters in your computer system and modify them for the current situation.

Appeal letters should include the following:

- Date of your letter
- Name of the particular individual to whom you are addressing your appeal. If you don't have a name, call the payer and obtain one.
- Title of the individual to whom you are addressing the appeal
- Complete address, including department to which you are sending the appeal
- Reason for the letter
- Subscriber name, patient name, date(s) of service, certificate number, precertification number, internal patient account number, and amount of claim being appealed
- Include language from the contract or the billing manual, if relevant
- If you have resubmitted the claim numerous times prior to the denial, be sure to tell the payer
- Send the appeal letter certified mail

Familiarize yourself with the response time for an appeal as contained in the payer's billing manual or contract. Always follow up on your appeal at set timeframes

When appealing a denied claim,

- Be respectful of the individual receiving your letter.
- Involve your patient in the appeal process. The patient is paying the premiums and a satisfied patient will want the provider paid.

9.3 Collection Policies and Procedures for Submitted Claims

The collection of outstanding insurance claims requires a high level of research and review:

- All outstanding claims are examined for accuracy and adequacy of documentation in preparation for re-submission.
- All claims require the same basic information, which is either collected or verified as correct from various components of the RPMS.
- All private insurance (inpatient and outpatient) claims are filed in the respective patient financial folders, which are readily available for retrieval.

Outstanding claims are identified utilizing the

- Explanation of Benefits for private insurance claims.
- Remittance Advice for Medicare and Medicaid claims.

Other sources in obtaining outstanding claims are the various reports available from the RPMS Accounts Receivable menu, such as 30/60/90/120 Day Age report.

The Accounts Receivable (A/R) staff should be responsible for keeping the batches in order by the remittance date. Uncompleted batch reports should be prepared on a weekly basis for Medicaid and Medicare. These reports allow the supervisor to monitor outstanding batches and/or Remittance Advices.

The first step in the process is to review the Explanation of Benefits or Remittance Advice to determine the status of the outstanding account. Accounts Receivable staff need to

- Log completed batches in the Tracking Log
- File remittances by payer according to remit date.

All Remittance Advices should be batched, logged, and filed. Explanation of benefits are logged and filed by received date. Follow-up of denied and outstanding claims are done by the latest remittance date.

The second step is to confirm that the insurance eligibility information listed in the RPMS Patient Registration application on Page 4 and Page 8 is accurate and current. If the eligibility has not been updated, the respective insurance company or carrier needs to be contacted either by a telephone call or on-line. Once verification is completed, updates will be made in RPMS.

9.4 Verifying Eligibility

9.4.1 Steps to Verify Eligibility via Telephone

1. Make contact with the appropriate insurance company or carrier and follow prompts or ask for the eligibility department.
2. Provide the patient's information for verification of coverage, such as social security number, date of birth, and gender of patient.
3. Ask for the effective date, any lapses in coverage, the termination date, and type of coverage.
4. Enter updated information in the RPMS Patient Registration application, on Page 4 and Page 8.

9.4.2 Steps to Verify Eligibility Online

Note: Various payers have on-line capabilities to verify eligibility which require setting up a user name and password.

1. Log onto website, enter password, and enter with information that is requested, such as Health Insurance Claim Number, social security number, name, and date of birth, gender, and the identification number for the recipients.
2. Enter date range for payers that require that information
3. Enter updated information in the RPMS Patient Registration application, on Page 4 and Page 8.

9.4.3 Entering Updated Eligibility Information in RPMS

1. Select the RPMS Patient Registration menu.
2. Select PAG or edit one of the patient pages.
3. Select P4.
4. Select PATIENT NAME and enter the patient's name, social security number, date of birth, and/or health record number.
5. Select upper case E to edit eligibility.
6. Enter the insurer number you want to edit.
7. Type "E" to edit or "A: to add an insurer.
8. Make necessary corrections or updates

9.5 Medicare Appeals Process

9.5.1 Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and again by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The Medicare appeals process is undergoing revision as a result of these amendments, and currently, new appeals process requirements are being phased-in.

By the completion of the phase-in process, and in addition to other changes, there will be a uniform claim appeals procedure for Part A and Part B claims. A table comparing the Medicare Appeals process is available in Part 5, Appendix C.

There will be a new stage (second level) in the appeals process, named **reconsideration**, which is different from the previous first level of appeal for Part A claims performed by Medicare Fiscal Intermediaries (FIs).

These new reconsiderations will be processed by Qualified Independent Contractors (QICs). For clarification, see Table 1: Appeal Rights for Redetermination Requests.

Note: As of October 1, 2004, reconsiderations are called redeterminations.

Table 1: Appeal Rights for Redetermination Requests

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Appeal Rights for Redetermination*
Part A/Part B	FI	On or after May 1, 2005	QIC
Part B	Carrier	On or after January 1, 2006	QIC
Part A	FI	Before May 1, 2005	ALJ
Part B	FI	Before May 1, 2005	HO
Part A	Carrier	Before January 1, 2006	ALJ
Part B	Carrier	Before January 1, 2006	HO

*Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

For requests filed in writing The date received is defined as

writing	the date received by the Medicare contractor in the corporate mailroom
person	the date of the office's date stamp on the request

Note: For Part A and Part B redeterminations issued *before* May 1, 2005, contractors will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. Contractors will continue to follow instructions in the Medicare Claims Processing Manual, Chapter 29, sections 50 and 60, in preparing case files.

CMS has developed and published *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers, and Billers*. This Medlearn guide is designed to be used as a self-help tool, and is available at this website:

<http://www.cms.hhs.gov/MedlearnProducts/>

Additional information about this guide can be found in the 2005 Medlearn Matters article SE0540, *CMS Releases New Educational Guide on Remittance Advice (RA) Notices*, which is available at this website:

<http://www.cms.hhs.gov/MedlearnMattersArticles/>

9.5.2 General Appeals Process in Initial Determinations (CMS CR 4019)

Note: The Centers for Medicare & Medicaid Services (CMS) revised the Medlearn Matters article on Nov. 18, 2005.

CMS has released an article that discusses the general appeals process in initial determinations and references pertinent information in Sections 200 to 260 in Chapter 29 of the *Medicare Claims Processing Manual*.

The article, titled “MMA - Changes to Chapter 29 - General Appeals Process in Initial Determinations,” (MM4019, October 7, 2005) is available at this website:

<http://www.cms.hhs.gov/MedlearnMattersArticles/>

Providers may reference CR 4019, Pub. 100-04, Transmittal 695, dated Oct. 7, 2005, for this information. The CMS transmittal is available in its entirety at this website:

<http://www.cms.hhs.gov/Transmittals/downloads/R695CP.pdf>

9.6 The Revised Medicare Appeals Process

(For Medicare Part A Fee-for-Service Appeals for Redeterminations issued by FIs on or after May 1, 2005, and Medicare Part B Fee-for-Service Appeals for Redeterminations issued by Carriers on or after January 1, 2006)

Effective for all initial determinations made on or after May 1, 2005, are new appeal rights for Medicare providers. Providers who submit claims to FIs will have the same right to appeal claims as beneficiaries. Accordingly, FIs will no longer use RA remark code MA44 for initial determinations made on or after May 1, 2005.

This means that FIs will not have to determine whether a provider submitting as appeal has the right to appeal, nor will they have to evaluate appointment of representative forms submitted by providers representing beneficiaries. In the past, non-participating suppliers accessed the appeals process by acting as the beneficiary’s appointed representative in situations where they might not otherwise have had appeal rights.

Section 1869(b)(1)(C) permits a beneficiary to assign his or her appeal rights with respect to an item or service to a provider or supplier. This assignment of appeal must be made using the CMS standard form, CMS 20031, *Transfer (Assignment) of Appeal Rights*, which is available at this website:

<http://www.cms.hhs.gov/CMSForms/>

9.6.1 First Level of Appeal - Redetermination

Parties who are not satisfied with the initial determination of their claim have the right to appeal that decision. For requirements for written redetermination requests made on or after May 1, 2005, see the *Medicare Claims Processing Manual* (pub# 100-4), Chapter 29, Section:

- 40.2.1(B) and 50.3.1(A) for beneficiary requests
- 40.2.1(C) and 50.2.1(B) for provider and State appeal requests.

The manual is available at this website:

<http://www.cms.hhs.gov/manuals/>

Unlike appeal requests filed before this date, provider and State appellants do not need to specify the date of initial determination in their requests.

Most Part A appeal requests will be made using the prescribed form, CMS 20027, *Medicare Redetermination Request Form*, available at this website:

<http://www.cms.hhs.gov/CMSForms/>

If a fully completed Form CMS-20027 is not used to express disagreement with the initial determination, the appeal request must contain the following information:

- Date of initial determination;
- Beneficiary name;
- Medicare Health insurance Claim Number;
- Name and address of provider of service;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that complies with the Medicare claims filing instructions. Ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form);

- Which item(s), if any and/or service(s) are at issue in the appeal; and
- The signature of the appellant.

During the transition period, requests for redeterminations of appeal decisions (determinations) effective for all initial determinations made on or after May 1, 2005 should go either to the QIC, the Administrative Law Judge (ALJ), or the Hearing Officer (HO), depending on whether the claim is a Part A or Part B claim; whether the Medicare contractor who issued the initial claim decision is an FI or a carrier; and the date of the claim. (see Table 2.)

A request for redetermination must be filed *in writing* within 120 days of the date of receipt of the notice of initial determination (either the Medicare Summary Notice (MSN) supplied to the beneficiary, or the Remittance Advice (RA) supplied to the provider. Provider and State appellants no longer have to specify the date of the initial determination in their requests. Medicare contractors may consider as good cause for late filing written redetermination requests that are mailed or personally delivered to CMS, SSA, Railroad Review Board (RRB) office or another Government agency, mailed in good faith and within the time limit, but do not reach the appropriate Medicare contractor until after the time period to file a request expired.

FIs are not required to send the appellant a letter acknowledging the receipt of a redetermination request, however, an Automated Correspondence System (ACS) will be created to house redetermination request information. This information will be accessible to providers within the Direct Data Entry (DDE) system for 90 days after receipt of the redetermination request and will allow providers to view which appeals were received by the FI and which appeals need to be resubmitted.

The redetermination is an independent examination of the claim file made by FI personnel who were not involved in the original determination decision. This person examines each aspect of each service in the claim. If there is doubt that the request is specific or general, a general redetermination is performed. For appeals initiated by the State, the FI will request that the State, or the parties who are authorized to act on behalf of the Medicaid State Agency will obtain and submit the necessary documentation.

Once the written redetermination appeal has been filed, Medicare providers and beneficiaries will receive a Medicare Redetermination Notice (MRN) from the FI for any partially favorable or unfavorable decision made on a redetermination request that was made on or after October 1, 2004. This written notification of the redetermination decision will provide complete, accurate and understandable information about the redetermination decision. All redeterminations will be completed and mailed within 60 days of the receipt of the request for redetermination.

CR3530, *Appeals Transition – BIPA 521 Appeals* (MM3530), discusses the revisions to the Medicare appeals process for FIs. A copy of the new Medicare Appeal Decision letter is attached to CR3530 (exhibit 2), and is available at this website:

<http://www.cms.hhs.gov/MedlearnMattersArticles/>

Note: The revisions discussed in CR3530 do not apply to claims submitted to Medicare carriers and/or redeterminations processed by carriers.

9.6.2 New Language for Redetermination Letters

Note: This does not apply to carriers and/or redeterminations processed by carriers.

FIs will change the Medicare Redetermination Notice (MRN) for redetermination decisions issued on or after May 1, 2005. There is no longer a minimum amount in controversy (AIC) requirement to move to the next level of appeal (QIC).

The MRN will show that providers who disagree with the redetermination decision will have 180 days to appeal to a QIC. The MRN will include a form to use for requesting reconsideration from the QIC. If this form is not used to request an appeal, providers must include the required information in the letter requesting the appeal, and must include the name of the contractor that made the redetermination.

Providers should, in particular, note the instructions on the MRN related to the submission of evidence to support their appeal. All evidence must be presented before the reconsideration is issued. Providers will not be able to submit any new evidence in subsequent appeal levels, unless they show good cause for not presenting evidence to the QIC.

The request for a reconsideration form will be included with the MRN and it will include the address of the QIC. If you send your request to the wrong QIC or to the FI in error, the error will be corrected and the request for appeal will be honored.

9.6.3 Second Level of Appeal - Reconsideration

Only the QIC has the authority to dismiss a request for reconsideration. This applies even when it appears that the request does not meet the requirements for requesting reconsideration.

A provider or State request for reconsideration must be made either on the CMS 20033 *Medicare Reconsideration Request Form*, available at this website:

<http://www.cms.hhs.gov/CMSForms/>

or as shown in the attachments to CR3530; or the request must contain the following information:

- Beneficiary's name
- Medicare health insurance number
- Specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service
- Name and signature of the party or representative of the party making the request; and
- Name of the FI that made the redetermination

In many cases, the QIC's decision will be effectuated (payments issued) by the FI; however, the FI will not effectuate a decision based on correspondence from any party of the reconsideration. The FI will take action only in response to a formal decision from the QIC.

If the decision is favorable and the amount to be paid is specified, the FI will effectuate the decision within 30 calendar days of the date of the QIC's decision or from the date written assurance from the provider is received. If the amount to be paid must be computed, the decision must be effectuated within 30 days of the time the amount was computed.

9.6.4 Third Level of Appeal - Administrative Law Judge (ALJ) Hearing

For Part A and Part B redeterminations issued before May 1, 2005, FIs will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. For redeterminations issued on or after May 1, 2005, the QIC will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

Often the FI will be responsible for effectuating the ALJ's decisions. The FI will take effectuation action only in response to a formal decision by the ALJ.

If the decision is favorable and the amount to be paid is specified, the FI will effectuate the decision with 30 calendar days of the date of the ALJ's decision or from the date the written assurance from the provider is received. If the amount to be paid must be computed, the decision must be effectuated within 30 days of the time the amount was computed.

9.6.5 Fourth Level of Appeal - Departmental Appeals Board (DAB)

Appeals should be made to the DAB or the ALJ Hearing Office. Appeals must be filed within 60 days of the date of receipt of the ALJ hearing or dismissal notice. The DAB may review an ALJ decision on its own, or may decline review of an appeal.

9.6.6 Fifth Level of Appeal - Federal District Court

Appeals must be filed within 60 days of the date of receipt of DAB decision or declination of review, and the amount in contention (AIC) must be at least \$1000 and for requests made or after January 1, 2005, the AIC must be at least \$1050. A request filed with the contractor is considered to have been filed as of the date the contractor received it.

Agency referrals

The AdQIC will be responsible for reviewing ALJ decisions and deciding whether an agency referral is appropriate for decisions issued after May 1, 2005. For all ALJ decisions issued by SSA ALJs, the FI remains responsible for this activity. The FI will no longer be responsible for reviewing ALJ decisions issued by HHS ALJs.

Additional Information

Among other topics, Medlearn Matters article MM3530, and the related CR3530 *Appeals Transition - BIPA Section 521 Appeals* contain appeals related information about

- Redetermination letters for fully favorable decisions, decision making time frames and extensions to the 60 day decision-making time frame;
- Requirements for written redetermination requests effective with initial determinations made on or after May 1, 2005;
- Consolidating requests for multiple parties on redetermination requests received on or after May 1, 2005;
- Filing reconsideration requests on redeterminations issued on or after May 1, 2005 (QIC jurisdictions);
- Requirements for reconsideration requests
- Overpayments and reopenings
- QIC decisions
- Appealing and vacating dismissals, and dismissal letters
- Incomplete requests
- Dismissal appeals and dismissal letters
- ALJ hearings
- Incomplete requests
- Preparing case files for ALJ hearings

The article is available at this website:

<http://new.cms.hhs.gov/MedlearnMattersArticles/>

9.7 Medicare Part B Appeals Process - Carriers

For Part B appeals, the Medicare regulation **42 CFR 405.807** states that a party who is dissatisfied with an initial determination may request that the contractor make a redetermination.

9.7.1 Who Can Appeal

- Providers (including physicians), as defined in **42 CFR 400.202**, who have appeal rights (**42 CFR 405.710(b)**).
- Physicians and Suppliers with appeal rights as specified in regulations at **42 CFR 405.801(b)**, accepting assignment on the claim at issue, and suppliers with refund requirements under section **1842(1)(1)**, **1834(a)(18)**, or **1834(j)(4)** of the Act.
- Beneficiaries and their authorized representatives
- After December 7, 2000, the Medicaid State agency or the party authorized to act on behalf of the Medicaid State agency.

Reviews are based on the following criteria:

- If the services and charges you provided were reasonable and necessary. Medicare will conduct a new, independent, and critical reexamination of the facts regarding denial or reduction in payment.
- If the services were covered and arbitrarily denied.
- You did not know and could not reasonably have been expected to know that Medicare would not pay for the service.
- You notified the beneficiary that Medicare would likely deny payment before you furnished the service.

There are two specific instances that are not initial determinations regarding claims for benefits under Medicare Part B:

- Any determination that CMS or SSA has sole responsibility for making, such as whether an independent laboratory meets the conditions for coverage of services or whether a Medicare overpayment claim should be compromised or a collection action terminated or suspended; and
- Any issue or factor that relates to hospital insurance benefits under Medicare Part A.

Further, a party may not appeal your use of the Physician Fee Schedule.

The initial determination is binding unless a party to the initial determination, such as the beneficiary, physician, supplier, or facility requests an appeal. The Medicare Part B administrative appeals process is available to resolve each party's questions or concerns about payment and coverage decisions. In instances where appeal rights have been exhausted or lapsed, you may have the authority to reopen your determination.

The Part B appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal, except for two specific situations:

- 1) Claims for payment not acted upon with reasonable promptness
- 2) Reopened determinations

Table 3 Medicare Part B Fee-for-Service Appeals Process - Carriers

Appeal Level	Time to File (TTF) Limit	Notes
1 - Redetermination (Beginning October 1, 2004, reviews will be called "redeterminations.")	TTF = 120 days from date of the notice of initial determination (the carrier allows 5 days beyond the date of notice for mail delivery)	Minimum amount in controversy (AIC) = None TLP = Complete 95% within 45 days of receipt of request, and all within 60 days of receipt of request.
2 - Hearing Officer (HO) hearing	TTF = 6 months from date of redetermination (allow an additional 5 days for mail delivery)	AIC = At least \$100 remains in controversy
3 - Administrative Law Judge Hearing (ALJ)	TTF = Filed with 60 days of receipt of HO hearing decision	AIC = At least \$100 remains in controversy
4 - Departmental Appeals Board (DAB) Review	TTF = Filed within 60 days of receipt of ALJ hearing decision/dismissal	AIC = None
5 - Federal Court Review	TTF = Filed within 60 days of receipt of DAB decision or declination of review by DAB	¹ At least \$1,050 remains in controversy Must be filed with the district court and not the contractor.

1. In 2005, the Amount in Contention (AIC) requirement for an Administrative Law Judge (ALJ) hearing and Federal District Court will be adjusted in accordance with 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, rounded to the nearest \$10.

9.7.2 Aggregation of Claims

Under **42 CFR 405.815**, claims with an amount in controversy (AIC) greater than \$0 may be combined to meet the amount in controversy (or contention) requirements. The decision about whether the AIC requirement has been met is made by the Hearing Officer (HO) at the HO level, and by the Administrative Law Judge (ALJ) at the ALJ level.

For further information, see the *Medicare Claims Processing Manual* (100-4), Chapter 29, Section 60.6.5, which is available at this website:

<http://www.cms.hhs.gov/manuals/>

9.7.3 Good Cause

When a request for redetermination or Hearing Office hearing is not filed within the time-to-file limit and where there is sufficient evidence or other documentation supporting a finding of good cause, the time limit (120 days for redetermination or within 6 months for Hearing Office dismissal) can be extended.

Good cause may be found when the record clearly shows, or the beneficiary alleges and the record does not negate, that the delay in filing was due to one of the following:

- Circumstances beyond the beneficiary's control, including mental or physical impairment (such as disability or extended illness), or significant communication difficulties
- Incorrect or incomplete information about the subject claim furnished by official sources (Social Security Administration (SSA), CMS or the contractor) to the individual, such as whenever a beneficiary is not notified of his appeal rights or the time limit for filing
- Delay resulting from efforts by the beneficiary to secure supporting evidence, where the individual did not realize that such evidence could be submitted after filing an appeal
- Unusual or unavoidable circumstances, the nature of which demonstrates that the beneficiary could not reasonably be expected to have been aware of the need for timely filing
- Destruction by fire or other damage of the individual's records, when the destruction was responsible for the delay in filing

Good cause for providers, physicians, or other suppliers can be found when the delay in filing was due 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 (SSA)) to the provider, physician, or supplier; **or**
- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for review or Hearing Office hearing. These may include floods, fire, tornados or other natural disasters.

If good cause for late filing is not found by the Hearing Office, the Hearing Office may refer the appeal to the contractor to consider reopening. If the contractor does not find good cause for the late filing of a request for redetermination, it may determine whether the case has any basis for reopening and revising its determination.

9.8 Medicare Part B Appeals Process

9.8.1 First Level of Appeal - Redetermination

A facility or provider dissatisfied with the initial determination on a Part B claim may request by telephone or in writing a redetermination of their initial determination.

The redetermination appeal can be filed with the contractor by telephone or in writing, and must be filed within 120 days of the date of the notice of initial determination (MSN or RA) received in the corporate mailroom by the contractor (minus 5 days to allow for normal mail delivery).

A fully completed CMS 20027 *Medicare Redetermination Request Form* constitutes a request for redetermination. The form is available at this website:

<http://www.cms.hhs.gov/CMSForms/>

If the form is not used, a written redetermination request must include the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/physician/supplier or item/service;
- Date of initial determination;

- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that complies with the Medicare claims filing instructions. Ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form);
- Which item(s), if any and/or service(s) are at issue in the appeal; and
- The signature of the appellant

If the Remittance Advice (RA) is attached to the redetermination request and the dates of service are highlighted or emphasized on the attached RA, but the redetermination request does not itself contain the dates of service, it is still an acceptable redetermination request. If an initial determination on a claim has not been made, there are no appeal rights on that claim.

Some letters and calls are considered inquiries and not requests for redeterminations. These communications may include the following characteristics:

- It is clearly limited to a request for an explanation of how Medicare calculated payment.
- It is a status request.
- It is a request for information.
- It is a request for a second copy of a notice.
- There is not an initial determination.

The carrier must complete 95% of requests within 45 days of receipt of request, and all requests within 60 days of receipt of request. The date of receipt is defined as the date the request for redetermination is received in the corporate mailroom (written requests) or on the telephone (telephone requests).

If the determination is a full reversal (fully favorable), the contractor will send an adjusted MSN or RA to all parties of the appeal. This will provide the beneficiary information about his or her financial liability with regard to the claim(s) that are now payable. An example of a redetermination letter can be found in the *Medicare Claims Processing Manual*, Chapter 29, Section 60.11.6.

A party to an appeal may appoint a **representative** to handle the appeal by completing Form CMS-1696, *Appointment of Representative* or may submit the required information in writing. The form is available at this website:

<http://www.cms.hhs.gov/CMSForms/>

To be valid,

- The representative must be an individual, not an organization, **and**
- Form CMS-1696 (or written request) must be signed by the representative within 30 calendar days of the date that the beneficiary or other party signs, and is valid for no more than one year from the date it was signed by the party making the appointment or the date of acceptance by the representative.

The reviewer making the redetermination must comply with, and must be bound by, all applicable statutory and regulatory provisions. The reviewer may not overrule the provisions of law or interpret them in a way different than CMS does; nor may the reviewer comment upon legality, constitutional or otherwise, of any provision of the Act, regulations or CMS policy review determination.

The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, program memoranda, national coverage determinations, and carrier-issued local medical review policies.

9.8.2 Telephone Review Procedures

A telephone review can be requested and performed on the phone. Both are completed through a review determination letter or other notice.

Whether a request for review is made by telephone or is conducted and completed as a telephone review depends on the issues at hand and the complexity of the matters involved. Telephone reviews should be limited to resolving minor issues and correcting errors, and should not involve anyone other than the redetermination analyst.

The appellant has 120 days after the date of the notice of initial determination to request a redetermination by telephone. If a more in-depth review is not necessary, and information and documentation was faxed during or prior to the telephone review, the reviewer may be able to inform the appellant of his or her decision at the conclusion of the call, or via a follow-up phone call.

9.8.3 Second Level of Appeal - Hearing Office Hearing

A party, who is dissatisfied with a review determination where at least \$100 remains in controversy, may request a Hearing Office hearing.

The Hearing Office hearing is an independent review of the claim by a hearing officer. The hearing process gives a dissatisfied provider or facility the opportunity to present the reasons for his/her dissatisfaction and to receive a new decision based on the evidence developed at the hearing.

If a redetermination has not been issued, there is no right to a Hearing Office hearing (except for claims not acted upon in a reasonable time by the contractor, and for appeals of revised initial determinations where \$100 or more remains in controversy).

The request for a Hearing Office hearing can be filed with any of the following:

- the contractor
- CMS
- an SSA office
- the RRB for RRB beneficiaries

The request must be filed within 6 months of the date of the notice of the redetermination or revised initial redetermination (plus 5 days for mail delivery).

The request may be any clear expression, in writing, by a party (or representative) that contains the necessary information to complete the appeal and states that the appellant is not satisfied with the review determination. Form CMS 1965, *Request for Hearing - Part B Medicare Claim*, can be used for this purpose, and is available at this website:

<http://www.cms.hhs.gov/CMSForms/>

The written inquiry must be stamped with the date of receipt in the corporate mailroom and tracked until a final answer is provided. Telephone and other inquiries (such as in-person or electronic) should be logged and tracked until the final answer is provided.

Requests that are filed incorrectly to a contractor that did not make the initial review decision/determination will be forwarded to the correct contractor as soon as possible. A request for a Hearing Office hearing that was filed prior to a redetermination should be handled as a request for redetermination.

The contractor or Hearing Officer who is assigned the request must send a letter to the appellant acknowledging receipt of the hearing request within 21 calendar days of the receipt of the request. Carriers must issue 90% of final determinations within 120 days of the date of receipt of request of the Hearing Office hearing (FIs function as carriers when processing Part B Hearing Office hearings.)

For telephone or in-person hearings, the Hearing Office must issue a decision no later than 30 days after the date that the hearing was held (unless the appellant has additional documentation to be considered after the telephone or in-person hearing).

9.8.4 Hearing Office Hearing Types

There are three kinds of Hearing Office hearings that can be requested by the appellant:

- In-person
- Telephone
- On-the record (OTR)

For the **in-person hearing**, the facility/provider/beneficiary can present both oral testimony and written evidence and has the right to refute or challenge the information.

A **telephone hearing** offers a convenient and less costly alternative to an in-person hearing, but it is not suited to every person or every case.

The major advantage of an **OTR hearing** is the speed with which the hearing is held and the decision is rendered. The same format as the in-person hearing is followed, except the decision is based on the facts that are in the file and/or additional information.

Note: Where an appellant specifically requests an OTR hearing, the resulting OTR hearing decision is not a POTR decision, and the appellant does not have a further option of then requesting an in-person or telephone hearing.

Hearing Office Hearing Review Process

An appellant who requests either an in-person or telephone hearing must be given adequate notice of the date, time, and place of the hearing and the specific issues to be determined. The Hearing Office must provide a written notice to the appellant and his/her representative before conducting the in-person or telephone hearing.

The appellant must receive the notice before the hearing takes place, allowing sufficient time to review it and to prepare for the meeting. Meetings can be rescheduled or adjourned on the motion of the Hearing Office for good and sufficient reasons (illness, certain scheduling difficulties, abusive or violent actions during the hearing).

Effectuation (payment) of Hearing Office hearing decisions must be initiated within 30 calendar days of the date of the decision, and 100% of decisions must be effectuated within 60 calendar days of the date of the decision.

Durable Medical Equipment (DME) Hearings

Durable Medical Equipment Regional Carriers (DMERCs) should accept transfer of in-person hearing requests from other DMERCs, because the determination of claims processing jurisdiction is based on the location of the beneficiary. Thus, suppliers must request hearings from the DMERC that processed the claim at issue.

9.8.5 Third Level of Appeal - Administrative Law Judge (ALJ) Hearing

If the appellant is dissatisfied with the determination made by the Hearing Office, and the amount in controversy is at least \$100, the appellant may request an in-person hearing before an Administrative Law Judge.

Requests for Part B ALJ hearings must be filed in writing with the contractor, at an RRB office (for qualified RRB beneficiaries), or with CMS, or at an SSA office within 60 days of the date of the receipt of the Hearing Office decision. The request must be in writing and filed within 60 days of the date of the carrier's fair hearing decision of record.

Aggregation

You may combine this claim with other claims to meet the \$100 amount in controversy requirement, as long as the appeal is timely filed for all claims at issue, and all claims at issue are at the proper level of appeal.

The contractor will acknowledge the request for a Part B ALJ hearing by sending the ALJ letter to the appellant within 30 calendar days of its receipt of the request in the corporate mailroom.

Supporting Documentation

For claims being submitted for an appeal, the responsibility for gathering and submitting documentation that supports claims and appeals rests with the provider and/or the facility. Documentation sources that have been proven useful to providers/facilities include.

- X-ray reports
- Test results
- Medical History
- Documentation of severity or acute onset
- Consultation Reports
- Billing Forms
- Referrals
- Plan of Treatment
- Nurse's Notes
- Copies of communications between physician and/or beneficiary, hospital, laboratory or others.

ALJ Hearing Review Process

The ALJ will either issue a decision based on the request for a Part B ALJ hearing or will issue an order of dismissal. If the decision of the ALJ requires effectuation on the part of the contractor, the contractor will wait to hear the ALJ's formal decision.

When effectuating the decision, the contractor will use the payment policies that were in effect on the date the claim was first submitted for processing, unless specifically directed otherwise.

The decision will be effectuated within 30 days of the receipt of the ALJ decision, if

- the decision is partially or wholly favorable,

- gives a specific amount to be paid, and
- is not referred to the DAB.

If the amount must be computed, then effectuation will occur no later than 30 calendar days of the date of receipt of the official ALJ decision. Duplicate ALJ decisions should be brought to the attention of the RO and OHA immediately for resolution.

9.8.6 Fourth Level of Appeal - Departmental Appeals Board Review

The Department Appeals Board (DAB) may choose to review an ALJ's decision or dismissal for any of the following reasons:

- There was an error of law.
- The ALJ decision/dismissal was not supported by substantial evidence.
- The ALJ abused their discretion.
- There is a broad policy or procedural issue that may affect the general public.

The DAB reviews requests for review and makes final decisions whether to review or decline to review ALJ decisions, as well as ALJ orders of dismissal.

The DAB will request all case files from the specialty contractor, who has responsibility to receive and store the files sent by ALJs after they make their decisions.

Effectuation of DAB decisions must be initiated within 30 days of the contractor's receipt of the DAB decision, and completed within 60 days.

9.8.7 Fifth Level of Appeal - U.S. District Court (Court) Review

An appellant, who is not satisfied with the DAB decision, may request a court review of the DAB decision. This appeal must be filed with the District Court and not with the contractor. The Court may remand the case back to the DAB or the ALJ.

In rare cases, the Court may require effectuation on the part of the contractor. In this case, the contractor will contact its CMS regional office (RO) appeals contact for instructions before taking any action.

9.9 General Guidelines for Writing Appeals

The appeals correspondence should be written so that anyone can easily understand the reason why any of the services were not covered or could not be full reimbursed, as well as actions that can be taken if the provider or facility disagrees with that decision. In addition, the following guidelines should be followed to the extent possible:

- Keep the language as simple as possible.
- Do not use abbreviations or jargon.
- Choose a positive rather than a negative tone, whenever possible. Avoid words or phrases which emphasize what you cannot do.
- If possible, avoid one-sentence paragraphs, uneven spacing between paragraphs, or other formatting that makes the document difficult to read.

9.10 Quality Control

Records must be kept of all inquiries. Appropriate management reports and reports requested by CMS will be produced from these records to aid in assuring that control standards for the inquiries and the quality of responses to the inquiries are maintained.

The appraisal requirements need to include the following:

- **Accuracy and Correctness**

The information in letters should be correct with regard to Medicare policy and your data. Taken as a whole, the information will increase the inquirer's overall understanding of the issues that prompted the inquiry. Letters should have good grammatical construction, sentences of varying length, and paragraphs generally containing no more than five sentences.

- **Responsiveness**

The response should address the inquirer's major concerns and state an appropriate action to be taken.

- **Tone/Clarity**

A clear statement of issues should be presented in the warmth and genuineness of a letter. The tone of the communication should be professional and customer friendly.

9.11 Additional Resources

If you have additional questions about the Medicare claims appeals process, please refer to your local FI. To find the toll free phone number for your local FI or carrier, go to this website:

<http://www.cms.hhs.gov/MLNGenInfo/>

For your convenience, the following list summarizes the references to documents in this chapter.

- *Medicare Claims Processing Manual* (100-4), Chapter 29: “Appeals of Claims Decisions,” which is available at this website:

<http://www.cms.hhs.gov/manuals/>

- *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers, and Billers*, which is available at this website:

<http://www.cms.hhs.gov/MedlearnProducts/>

- CR3530: *Appeals Transition - BIPA 521 Appeals* (MM3530)
- CR3942 *Changes to Chapter 29 - Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation date May 1, 2005)* (MM3942)
- CR4019 *Changes to Chapter 29 - General Appeals Process in Initial Determinations* (MM4019)
- SE0540 *CMS Releases New Educational Guide on Remittance Advice (RA) Notices*

To download copies of these documents (CR3530, 3942, 4019; SE0540), go to the **2005 Medlearn Matters Articles** at this website:

<http://www.cms.hhs.gov/MedlearnMattersArticles/>

- Form CMS 20031, Transfer (Assignment) of Appeal Rights,
- Form CMS-1696, Appointment of Representative
- Form CMS-1965, Request for Hearing - Part B Medicare Claim

To download copies of these CMS forms (CMS 20031, 1696, 1965), go to this website:

<http://www.cms.hhs.gov/CMSForms/>