Education Makes the Difference

Appeals

TrailBlazer HEALTH ENTERPRISES, LLC℠

CMS CENTERS for MEDICARE & MEDICAID SERVICES

2006 Part B

TX MD DC DE VA & Indian Health

★★ IMPORTANT ★★

The information provided in this manual was current as of April 2006. Any changes or new information superseding the information in this book are provided in the Medicare Part B newsletters with publication dates after April 2006. Medicare Part B newsletters are available at: www.trailblazerhealth.com/pubs.asp?

★★ IMPORTANT ★★

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APPEALS

NOTE: The appeal guidelines listed in this section are effective for initial determination dates on or after Jan. 1, 2006. For initial determination dates prior to Jan. 1, 2006, previous appeal guidelines may apply. For specific instructions, please refer to the back of the Medicare Remittance Advice (MRA).

RESUBMIT, REOPEN OR APPEAL?

RESUBMIT

When a claim is rejected because certain information was missing, the claim may not be appealed. Payment can only be considered once the claim is resubmitted with the omitted information.

When to Resubmit

Some examples of rejected claims that should be resubmitted are:

- Invalid procedure codes and/or ICD-9-CM codes.
- Incomplete information, such as:
  - Performing provider numbers.
  - Purchased test criteria.
  - Drug name and dosage.
  - Operative reports.
  - Invalid Health Insurance Claim Numbers (HICN).
  - Services payable by a primary insurer.

Paper Claims

If resubmitting the claim on paper:

- Do not attach the remittance notice to the claim.
- Do not indicate/stamp “resubmit,” “second request,” “corrected claim”, etc. on the claim.
- Do not send these claims to any Medicare correspondence areas.

Reminder: Mandatory electronic claims filing still applies when resubmitting.

REOPEN

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing a claim.

What Claims Are Eligible for a Reopening?

In the case where a minor error or omission is involved, the provider can request that TrailBlazer **reopen** the claim so the error or omission can be corrected, rather than having to go through the appeals process.

Note: Items/services that were not previously submitted cannot be added through the reopening process.

What is Needed to Request a Reopening

When requesting a reopening, the provider must provide the following information:

- Beneficiary name.
- Medicare Health Insurance Claim Number (HICN).
- Name and provider number of provider/supplier of item/service.
- Date of service being questioned.
- Which items, if any, and/or services are at issue in the reopening request.
- Complete signature of requestor.

The following is a list of examples that can be corrected through the reopening process:

- Changes to number of services/units.
- Add, change or delete some modifiers.
- Procedure code changes.
- Billed amount changes.
- Add or change the referring physician.
- Dates of service changes.
- Place of service changes.

The following is a list of examples that are generally **inappropriate** for a reopening:

- Request submitted with notes or records.
- Additions or changes to some modifiers.
- An in-depth review is required.
- The need for additional documentation.
- Limitation of liability (waiver issues) that result in reversing a party's liability.
- Overpayment disputes or protests.
- Diagnosis changes/additions.
- Overpayments.
- The need for complex overpayment calculations or offsets.
- Medical necessity reductions.
- Review of operative reports, office notes, lab/path reports.

- The need for medical staff input.
- An initial determination date that is more than one year prior to the request for a reopening.
- Provider number changes.

Note: Along with the required information, it is acceptable to include a copy of the Medicare Remittance Advice (MRA) with the specific claim/patient information highlighted. Be very specific when requesting a written reopening.

Reminder: A reopening can be performed for minor error corrections and at the carrier's discretion. A reopening is not an appeal right. However, you can appeal a reopening decision.

APPEALS

Definition

An appeal is a written request to Medicare to reconsider a claim.

Who Can Appeal?

- Beneficiaries and their representatives.
- Medicaid state agency.
- A provider who has accepted assignment on a claim.
- The provider for certain non-assigned claims (for example, when the provider is liable for the service).

Note: If the physician requests an appeal, the beneficiary does not lose his right to appeal the claim.

Five Levels of Appeals

- Redeterminations.
- Reconsiderations*.
- Administrative Law Judge (ALJ).
- Departmental Appeals Board (DAB) review.
- Federal Court review.

* Reconsiderations – formerly known as Hearing Officer Hearings.

Each level of appeal must be completed before appealing to the next level. For example: An ALJ may not be requested until after the claim has had a redetermination and a reconsideration. Each level of appeal is outlined in detail on the following pages.

APPEALS (REDETERMINATIONS)

Our Mandate

The Medicare carrier is mandated to complete redeterminations within 60 days of receipt. The redetermination notice must be mailed to the parties within this 60-day period.

To process a redetermination as quickly as possible, all documentation relevant to the request should be filed. Otherwise, a redetermination will be made based on the information at hand.

Written Redetermination Requests

Written redetermination requests may be submitted on Form CMS-20027. When using Form CMS-20027, all items must be completed.

If Form CMS-20027 is not used, a written request may be submitted with all the following:

- Beneficiary name.
- Beneficiary's Health Insurance Claim Number (HICN).
- Dates of service for which the initial determination was issued. (The dates of service must conform to the Medicare claims filing instructions. Ranges of dates are acceptable only if a range of dates is properly reportable on a Medicare claim form.)
- Which item(s), if any, and/or services are at issue in the redetermination.
- Signature of appellant.

Providers may obtain the Form CMS-20027 from Medicare or download it from the CMS Web site at:

www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf

Time Limit

A request for a **redetermination** must be received by the Medicare contractor within 120 days from the date of the initial determination. (The date will appear in the top right-hand corner of the remittance notice.)

For Requests Filed in Writing

The date received is defined as the date received by the Medicare contractor in the corporate mailroom.

For Requests Filed in Person

The date received is defined as the date of the office's date stamp on the request.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE REDETERMINATION REQUEST FORM

1. Beneficiary's Name: _____

2. Medicare Number: _____

3. Description of Item or Service in Question: _____

4. Date the Service or Item was Received: _____

5. I do not agree with the determination of my claim. MY REASONS ARE:

_____

_____

_____

6. Date of the initial determination notice _____

(If you received your initial determination notice more than 120 days ago, include your reason for not making this request earlier.)

_____

_____

_____

7. Additional Information Medicare Should Consider: _____

_____

_____

_____

8. Requester's Name: _____

9. Requester's Relationship to the Beneficiary: _____

10. Requester's Address: _____

_____

11. Requester's Telephone Number: _____

12. Requester's Signature: _____

13. Date Signed: _____

14. ❑ I have evidence to submit. (Attach such evidence to this form.)
❑ I do not have evidence to submit.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

Form CMS-20027 (05/05) EF 05/2005

Reminder: Redetermination requests lacking required items are not returned to the provider. If any required item is missing, the redetermination request will be dismissed. The provider will be notified of the dismissal in writing.

Correct and Timely Response

To ensure a correct and timely response, physicians/suppliers should:

- Submit a complete form.
- Return a copy of the remittance notice (and claim, if possible).
- Be specific, identifying the service(s) in question and the need for the redetermination. Do not use the general term “please review” unless every service on the claim is in question.
- Provide any additional information needed with the redetermination request (i.e., operative report, description of service, name and dosage of drug, etc.).

Note: In situations where a provider requests an appeal and the issue involves a minor error or omission, TrailBlazer will treat the request as a request for a reopening.

REMITTANCE ADVICE

When making an adjustment to claim information as a result of a reopening or a redetermination, the original claim information is voided and replaced by the corrected data as if it were a new claim. Any original payment must be offset against other benefits due. Therefore, changes have been made to the information that is shown on provider remittance notices for adjusted claims.

When a claim is adjusted as a result of a redetermination or reopening, the remittance notice will include all services on the original claim, even if only one service was adjusted. The amount shown in the ALLOWED column will be the entire allowed amount for the service, and the amount shown in the PROV PD column will show the entire amount paid for the service, including any payment made on the original claim. The Total PROV PD amount less the PREV PD amount will equal the NET amount. The NET amount will be the additional payment the provider receives with his remittance notice.

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Example:

PERF PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME ---------	HIC 123456789A	ACNT 00000000	ICN 4605000000000	ASG Y	MOA MA67	MA18				
										MA03
XXXXXX	0115 011505 21	1	44626		2998.00	1417.43	0.00	283.49	CO-42	1580.57	1133.94
XXXXXX	0115 011505 21	1	45378	5951	976.00	102.40	0.00	20.48	CO-B6	771.21	81.92
									CO-59	102.39	
PT RESP	303.97		CLAIM TOTALS		3974.00	1519.83	0.00	303.97		2454.17	1215.86
ADJS: PREV PD	1133.94	INT	0.00	LATE FILING CHARGE	0.00						81.92
NET											

TOTALS: # OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
1	3974.00	1519.83	0.00	303.97	2454.17	1215.86	1133.94	81.92

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes

CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
42	Charges exceed our fee schedule or maximum allowable amount.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

	An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency
	(HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF
	recertified bed denial, or a home health denial because the patient was not homebound or was not
	in need of intermittent skilled nursing services, or a hospice care denial because the patient
	was not terminally ill, and either the patient or the provider is liable under Section 1879 of
	the Social Security Act, and the patient chooses not to appeal.
	If your carrier issues telephone review decisions, a professional provider should phone the
	carrier’s office for a telephone review if the criteria for a telephone review are met.
MA02	If you do not agree with this determination, you have the right to appeal. You must file a
	request for an appeal within 180 days of the date you receive this notice. Decisions made by
	a Qualified Independent Contractor (QIC) must be appealed to that QIC within 60 days.
MA67	Correction to a prior claim.
FB	Forwarding Balance

RECONSIDERATIONS

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869© of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous Hearing Officer Hearing.

Regulations require that appellants dissatisfied with a redetermination can request a reconsideration. A signed request with written expression of dissatisfaction must be received within 180 days of the date of receipt of the redetermination. There is no monetary threshold to be met. Reconsiderations will be processed by the Qualified Independent Contractor (QIC).

QUALIFIED INDEPENDENT CONTRACTORS (QICS)

Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) required Medicare to contract with QICs to perform second-level claim appeals, called reconsiderations.

What Is a QIC?

QICs are companies that will perform the second level of appeal for Medicare fee-for-service claims. They will conduct a reconsideration of your Medicare Part B appeal.

The QIC's reconsideration will differ from a hearing officer hearing in many ways:

- **Faster reconsideration time frame.** A QIC reconsideration must be completed within 60 days, as opposed to the 120-day time frame for a hearing officer hearing (with optional escalation).
- **Panel of health professionals review.** If the denial was based on medical necessity, the QIC must have a panel of physicians or other health care professionals with the appropriate clinical expertise to review a claim.
- **Detailed information in the decision letter.** The QIC must include a detailed explanation of the decision, including any pertinent facts and applicable regulations, and, in the case of a medical necessity denial, an explanation of the medical and scientific reason for the decision.

Time Limit

The time limit for requesting a reconsideration is 180 days from the date of the redetermination letter.

To Request a Reconsideration

Request a QIC reconsideration to:

Q²Administrators, LLC
Part B East Operations
P.O. Box 183092
Columbus, OH 43218-3092

ADMINISTRATIVE LAW JUDGE (ALJ)

Background

Regulations require that appellants dissatisfied with a QIC decision have a right to a hearing by an Administrative Law Judge (ALJ). The appellant has a right to an on-the-record or in-person hearing by an ALJ.

Amount in Controversy

For an ALJ hearing, the amount in controversy for initial determinations made on or after Jan. 1, 2006, must equal or exceed $110.

Note: Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by the percentage increase in 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. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Time Limit

An ALJ hearing must be requested within 60 days of the date of the QIC decision.

DEPARTMENTAL APPEALS BOARD

If a provider is still dissatisfied with the ALJ decision, he/she may file a request for a review with the Departmental Appeals Board (DAB) within 60 days of receipt of the ALJ decision/dismissal.

There is no amount in controversy for a DAB review.

FEDERAL COURT

The final level of appeal must be filed within 60 days of receipt of the DAB decision or declination of review by DAB to the federal court review. For a federal District Court hearing made on or after Jan. 1, 2006, the amount in controversy is $1,090.

Note: Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by 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. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

APPEALS PROCESS – QUICK CHART

APPEAL LEVEL	***TIME LIMIT FOR FILING REQUEST***	***MONETARY THRESHOLD TO BE MET***
1. Redeterminations	**120 days** from the date of receipt of the initial determination notice	**None.**
2. Reconsiderations	**180 days** from the date of receipt of the redetermination	**None.**
3. Administrative Law Judge (ALJ) Hearing	**60 days** from the date of receipt of the reconsideration	For requests filed on or after Jan. 1, 2006, at least $110 remains in controversy.
4. Departmental Appeals Board (DAB) Review	**60 days** from the date of receipt of the ALJ hearing decision.	None.
5. Federal Court Review	**60 days** from the date of receipt of DAB decision or declination of review by DAB	For requests filed on or after Jan. 1, 2006, at least $1,090 remains in controversy.

Note: Requests filed prior to Jan. 1, 2006, monetary amounts were:

- Hearing Officer Hearing $100 in controversy.
- ALJ $100 in controversy.

MANUAL REVISION HISTORY

2006 APPEALS MANUAL	
Date	***Description***
April 2006	Removed telephone reopening line information.