Dynamic Chiropractic

BILLING / FEES / INSURANCE

How to Retain More of Your Medicare Money, Part 4

THE APPEALS PROCESS

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You have prepared a solid treatment plan and carefully documented medical necessity for the care you have rendered. You have carefully informed that patient that Medicare will not pay for some services and may deny the rest. You submit the claim and sure enough, Medicare denies the service as medically unnecessary. Before you throw up your arms in disgust and send a bill to the patient, you should take the next step in protecting yourself and appeal that decision. Appealing a denial is critically important to you, the doctor, because each denial counts as an error on your personal Medicare profile. When you have too high of an error rate, you are put on review automatically.

The Telephone Reopening

"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process." The telephone reopening is designed to correct clerical errors such as mathematical or computational mistakes, transposed procedure or diagnostic codes, inaccurate data entry, etc. You may request a reopening within one year of the date of an initial determination. This is your first step and, in many cases, the only step that you need to take. If the problem cannot be corrected through the reopening process, you need to start the appeal process.

Appeals Process Step #1: Redetermination

"A party dissatisfied with an initial determination may request in writing that the contractor review its determination. A redetermination is the first level of appeal after the initial determination on Part A and Part B claims. It is a second look at the claim and supporting documentation and is made by a different employee." A request for redetermination can be filed on Form CMS-20027. The form is located at www.cms.hhs.gov/CMSForms. Click on "CMS Forms" at the left of the page.

You have 120 days from the date of receipt of initial determination to file a request for redetermination. The notice of initial determination is presumed to have been received five days from the date of the notice unless there is evidence to the contrary. There is no minimum monetary threshold to be met for filing a redetermination. This is when you present all supporting documentation available.

Appeals Process Step #2: Reconsideration

The request for reconsideration must be filed with the Qualified Independent Contractor (QIC) specified on the redetermination notice. The request for reconsideration must be made within 180 days of receipt of the redetermination. There is no minimum monetary threshold to be met for reconsideration. A request for reconsideration can be filed on Form CMS-20033. This form is also located at www.cms.hhs.gov/CMSForms. Click on "CMS Forms" at the left of the page. If you have

any more supporting documentation, this is your chance to present it. You will not be able to do so after this point without extenuating circumstances.

Appeals Process Step #3 Administrative Law Judge (ALJ)

"To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties." The request for an ALJ hearing must be filed within 60 days of receipt of the reconsideration. The amount remaining in controversy requirement for ALJ hearing requests made after Jan. 1, 2009 is $120.

A request for an ALJ hearing can be filed on Form CMS-20034. The form is located at www.cms.hhs.gov/CMSForms. Click on "CMS Forms" at the left of the page. You have the option of either requesting a hearing before the judge (which you must attend) or of requesting the judge review the documentation previously presented.

Appeals Process Step #4: Departmental Appeals Board (DAB)

"The level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued, but before judicial review is available is Appeals Council review. If a party requests the Appeals Council to review an ALJ's decision, the Appeals Council may review the decision and adopt, modify, or reverse the ALJ's decision, or remand the case to an ALJ for further proceedings. See, in general 42 C.F.R S 405.1108. However, when a party requests that the Appeals Council review an ALJ's dismissal, the Appeals Council may deny review or remand the case to an ALJ for further proceedings. In addition, the Appeals Council will decide cases that are escalated from the ALJ level without an ALJ decision or dismissal. See 42 C.F.R S 405.1108(d)."

Appeals Process Step #5: U.S. District Court

"The circumstances allowing for an appeal or escalation to the U.S. District Court level of review are limited, and articulated in 42 CFR 405.1136." "Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S. District Court. The amount remaining in controversy for requests made on or after January 1, 2009 is $1,220."

When to Involve a Lawyer

At some point in the appeals process you are going to need a lawyer. The first two steps are designed for beneficiaries or providers to do on their own and, as such, should not require legal assistance except in special situations. The ALJ step may or may not require legal assistance depending on whether you request a hearing or not. Remember that an ALJ hearing is a legal proceeding and that there are protocols and formalities that need to be observed.

If the ALJ hearing is a review of the evidence and does not require legal assistance, then the DAB review may not require the services of a lawyer. However, U.S. District Court review will definitely require legal assistance.

The decision on when to retain the services of a lawyer is one left to the individual. If you are asking yourself, "Do I need a lawyer?" then you probably do. Bear in mind that Medicare appeals require the services of attorneys who specialize in this area of law.

References

1. Chapter 34, Section 10, *Medicare Claims Processing Manual*.
2. Chapter 29, Section 310.1, *Medicare Claims Processing Manual*.
3. Chapter 29, Section 330.2(A), *Medicare Claims Processing Manual*.
4. Chapter 29, Section 340, *Medicare Claims Processing Manual*.
5. Chapter 29, Section 345, *Medicare Claims Processing Manual*.
6. Chapter 29, Section 345.1, *Medicare Claims Processing Manual*.

Part 1 of this article appeared in the Jan. 29 issue; part 2 ran in the Feb. 26 issue; and part 3 ran in the April 9 issue. This is the fourth of five articles discussing Medicare claims and strategies for ensuring proper reimbursement for services performed.

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