

Medicare and the Chiropractic Practice, Part 6

THE MEDICARE APPEALS PROCESS.

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Getting paid for what you do sometimes involves appealing claim denials. In the case of Medicare, the government maintains specific protocols for the appeals process. The following outline will assist you in knowing what is required to appeal a Medicare denial. The Chiropractic Summit recommends and encourages DCs to appeal all improperly denied claims (even if it is only one claim); historically, many DCs do not. Remember that appealing is a service not only to your patient, who has a right to have their payable covered services reimbursed, but also to your profession.

Overview of the Appeals Process

When an initial claim determination is made, and the claim is denied, participating physicians have the right to appeal. Physicians who do not take assignment on claims have limited appeal rights. Beneficiaries may transfer their appeal rights to non-participating physicians who did not accept assignment (and therefore do not have appeal rights). Form CMS-20031 must be completed and signed by the beneficiary and the non-participating physician to transfer the beneficiary's appeal rights. All appeal requests must be made in writing.

First convened in September 2007, the Chiropractic Summit represents leadership from some 40 organizations within the profession. The Summit meets regularly to collaborate, seek solutions, and support collective action to address challenges with the common goal of advancing chiropractic.

A major focus of the Summit is to improve practitioner participation, documentation, and compliance within the Medicare system. This article, the sixth in a series developed by the Chiropractic Summit Documentation Committee, focuses on the Medicare appeals process.

Medicare offers five levels in the Part B appeals process. The levels, listed in order, are *Redetermination* (performed by the carrier/MAC); *Reconsideration* (performed by a Qualified Independent Contractor); *Hearing* (performed by an Administrative Law Judge); *Review* (performed by the Medicare Appeals Council (within the Departmental Appeals Board); and *Judicial Review* (in U.S. District Court).

Level 1: Redetermination

A redetermination is the examination of a claim by carrier/MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a redetermination: A request for a redetermination may be filed on Form CMS-20027 (available at www.cms.gov/cmsforms/downloads/cms20027.pdf). In addition, a contractor-specific version can usually be found on the contractor's Web site. A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should include *supporting documentation* with their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination/denial.

Level 2: Reconsideration

If dissatisfied with the outcome of the redetermination, a reconsideration may be requested. A QIC (Qualified Independent Contractor) will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Requesting a reconsideration: A written reconsideration request must be filed within 180 days of the redetermination. To request a reconsideration, follow the instructions on the Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033, available at www.cms.gov/cmsforms/downloads/cms20033.pdf. Again, a contractor-specific version can usually be found on the contractor's Web site. If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the redetermination

The request for reconsideration should clearly explain why you disagree with the redetermination. A copy of the MRN, and any additional documentation you feel may be useful, should be sent with the reconsideration request to the QIC identified in the MRN.

Documentation that is submitted after the reconsideration request has been filed may result in an extension of the time frame a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing, and any other evidence relevant to the appeal, must be submitted prior to the issuance of the reconsideration decision. *Evidence not submitted at the reconsideration level may*

be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

Reconsideration Decision Notification: Reconsiderations are conducted "on the record" (based on the information submitted) and in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request. The decision will contain detailed information on further appeals rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable time frame, it will inform the appellant of their right to escalate the case to an Administrative Law Judge.

The Third Level of Appeal and Beyond

Our next article (part 7) will focus on the last three levels of appeal, with a focus on what is perhaps the most significant level, the Administrative Law Judge (ALJ), level 3. Historically, the ALJ level has proven to be the most favorable level for providers (although the vast majority have been won prior to reaching this level).

The members of the Summit Subcommittee on Documentation are Dr. Carl Cleveland III, Dr. Farrel Grossman, Dr. John Maltby, Dr. Peter Martin, Ms. Susan McClelland, Dr. Ritch Miller, Dr. Frank Nicchi, Mr. David O'Bryon, and Dr. Frank Zolli. Dr. Miller served as principal author of this article, with contributions from members of the subcommittee and the documentation working group.

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