Part B Insider (Multispecialty) Coding Alert

Appeals: Avoid Appeals Doldrums With Documentation

Cash-strapped carriers may begin pushing your appeals to the bottom of their in-boxes unless you know how to play the game.

The **Centers for Medicare & Medicaid Services** instructed carriers to warn providers that "failure to submit appropriate documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies may delay appeals development and determinations."

In other words, documentation is your ticket out of appeals purgatory.

But that's not all. CMS provides an exhaustive list of how to prioritize appeals in Program Memorandum AB-03-052. The agency has come up with seven different levels of priority for appeals, depending on a variety of factors. They are:

1. Finish carrying out all Administrative Law Judge and Departmental Appeals Board decisions and respond to DAB requests for case files.

Carriers should handle a favorable ALJ decision that gives an amount to be paid within 30 days, and a decision that requires the carrier to compute an amount should be handled within 30 days after the carrier finishes computing the amount. Carriers should also carry out unfavorable decisions within 30 days. If the carrier needs clarification from the ALJ, the clock doesn't start ticking until the carrier receives that clarification.

2. Adjudicate requests for telephone appeals.

3. Adjudicate written reconsiderations, reviews and Hearing Officer hearings from beneficiaries or their appointed representatives.

4. Adjudicate written requests for reconsiderations, reviews and HO hearings from providers, suppliers, states or others that are submitted with necessary documentation.

CMS says 95 percent of requests for review must be completed within 45 days of receipt of the request in the corporate mail-room. Carriers can consider a review completed when they've concluded the process that generates the decision letter for mailing to the parties, generated a decision letter, and initiated the adjustment action in the claims processing system.

As for HO hearings, carriers must issue 90 percent of all HO hearing decisions within 120 days of receiving the request for a hearing in their mailrooms. That includes signing a decision or generating a dismissal notice.

HO decisions should be carried out within 30 days after the hearing, CMS adds.

Carriers should process 75 percent of reconsiderations within 60 days of receipt in the corporate mail-room, and 90 percent of them within 90 days of receiving them.

5. Adjudicate written requests for reconsiderations, reviews and HO hearings from providers, suppliers, states or others that are submitted **without** necessary documentation.

6. Prepare, assemble and forward Part Aand Part B ALJ hearing case files that contain the proper documentation.

CMS says the carriers should forward requests for an ALJ hearing within 21 days of receiving them. But for aggregated cases that contain more than 40 beneficiaries or claims, the carriers should send them on within 45 days.

7. Deal with the ALJ hearing case files that lack the proper documentation.

8. Submit agency referrals to the DAB.

In general, carriers should use a "first in, first out" approach to appeals, CMS states. But during times of "limited resources," they should prioritize their workloads. CMS recommends using its own scheme to set priorities, but carriers can submit their own plan to the regional office.

If carriers do find their budgets becoming strained, they should submit a supplemental budget request before they start becoming ruthless about prioritizing appeals.