Part B Insider (Multispecialty) Coding Alert

APPEALS: If Losing Thousands Doesn't Appeal To You, Streamline Your Processes

Prepare now for quicker appeals turnaround

Starting this January, having your ducks in a row will be more important than ever when it comes to submitting appeals for denied claims.

When the **Centers for Medicare and Medicaid Services'** new appeals process kicks in, you'll only have one chance to get appeals right. If you don't include all the important information in your second-level appeal to the Qualif- ied Independent Contractor (QIC), you won't be able to add any more information except if there is "good cause."

Also, the timeframe to submit your QIC appeal will shorten from six months to 180 days as of next January. And the Administrative Law Judges (ALJs) who consider appeals after the QIC level will be Medicare specialists, instead of Social Security ALJs on loan.

So "you have to have your case better organized," says attorney **Alice Gosfield** at **Gosfield & Associates** in Philadelphia. "You're going to have to be much more on top of what you're doing."

You'll have to make sure your appeals have complete documentation the first time around, including pictures and all substantiating evidence, says **Barbara Cobuzzi**, president of **Cash Flow Solutions** in Cherry Hill, NJ.

Idea: You may have to set up better processes to manage appeals, so that every appeal runs more smoothly, Cobuzzi adds. "When you've got reliable processes, that's how you make sure you do things right." You should have a checklist of sources to help you assemble documentation for every appeal - and also substantiating sources like the CPT Assistant and Medicare Carrier's Manual to check in every case.

Do The Research At The Start

"Up-front research is really important now," says **Tammy Tipton**, president of **Appeal Solutions** in Blanchard, OK. "You really don't have time to gather information before you move on, you really have to do it in the first period before the [carrier-level] reconsideration."

You should have dedicated staff who work on appeals, says Tipton. Ideally, at least one person's time should be devoted entirely to appeals. Instead of having billers handle appeals, a separate appeals staff can be more familiar with deadlines and the new process. "They can be more aggressively focused on having the documentation for that first appeal," says Tipton.

Also, you may want to invest in "appeal management technology," such as denial tracking software so you know how long has elapsed since the denial.

Providers have been asking CMS to speed up the appeals process for a long time, so they can't really complain about shortened timeframes, says attorney **Michael Manthei** with **Holland & Knight** in Boston. "Overall for providers, it will be much better if [an appeal] goes quickly, even if it puts more of a burden on a provider to get his records together."

Most denials will be based on a sample of claims rather than a review of all files, or else an automatic edit will deny a whole category of claims, notes Manthei. Usually CMS will provide a spreadsheet with all the names and Medicare numbers of the patients affected. So it should be pretty easy to look up these files, Manthei notes.