

Part B Insider (Multispecialty) Coding Alert

Appeals: Know the 5 Levels of the Medicare Appeals Process

Hint: Reopen first, before you try for an appeal.

If you find the Medicare appeals process confounding, it may be time to review the stages of the appeals ladder.

Reopening and Redetermination Are 2 Different Things

As a Medicare provider, CMS allows you to appeal a claim decision you disagree with. "If a provider is dissatisfied and the remittance advice is an MA01, you have your appeal rights," reminds **Carleen Parker**, a provider outreach and education consultant with Medicare Administrative Contractor (MAC) NGS in the "How to Avoid Missed Determinations" webinar last month.

There are five levels of appeals for Medicare denials, and there are time constraints at the various levels, Parker indicates. Understanding how these levels build on each other is your first step toward understanding the appeals process. But, before you start down the rabbit hole, you may want to reopen your claim first, she suggests.

"You want to look to reopen it [the claim] first because there's a difference between reopening and redetermination," stresses Parker. "You don't want to request an appeal if you can simply fix the claim by reopening."

What that means: Reopening is a process for correcting a minor error or omission on a claim without having to pursue the formal appeals process. You can request a reopening online, by phone, or by written request once the claim has been finalized. During reopening, you can change items such as the charge, the place of service, the quantity billed, the date of service (if it's in the same calendar year), the procedure or diagnosis code, or a patient's Medicare number. You can even add a modifier during the reopening process.

Limitations: You can't use reopening to change the year on a date of service or to change billing provider information. Nor can you use reopening to add a line of service not billed on the initial claim, or for any change that requires additional documentation for a redetermination.

Review the 5 Levels of the Appeals Ladder

The five appeals stages are as follows:

Level 1: Redetermination: You can submit the appeal with proper paperwork within 120 days. The only hitch here is that this would go to the MAC that first denied the claim, so you can only keep your fingers crossed. "If you have to prove medical necessity by submitting documentation to substantiate your review, then it's a redetermination," Parker says.

Level 2: Reconsideration: For this round, you submit the appeal within 180 days from the date you received the redetermination. A Qualified Independent Contractor (QIC) reviews the claim. You stand a better chance of having a successful appeal here. Requests for Level 2 appeals can only be made in writing.

Level 3: Administrative Law Judge (ALJ) Hearing: No respite at Level 2? You can go on to file a written request within 60 days of the reconsideration, but remember, your claim must be worth at least \$160 to file a Level 3 appeal. The QIC prepares the case file and forwards it to the HHS Office of Medicare Hearings and Appeals. CMS assigns cases, and they have 90 days to decide on the appeal.

Level 4: Medicare Appeals Council (MAC) Review: No success with the ALJ? The Medicare Appeals Council is the next rung on the appeals ladder. You may then go ahead and file a request to the Department Appeals Board (DAB) for a MAC review within 60 days from the date of the ALJ hearing decision. Level 4 claims must also be worth at least \$160.

Level 5: Federal Court Review: If you feel like cracking on, you may file a request for a federal court review within 60 days of the DAB's decision. Claims for a Level 5 appeal must be worth at least \$1,630.

Tip: Documentation is the key to the success of any level of appeal, explains **Shelly Dailey, MSN, BSN, RN, CPHM**, Medicare home health and hospice clinical consultant at NGS in a webinar. Providers must include all pertinent information to avoid the dismissal of the case.