Part B Insider (Multispecialty) Coding Alert

Appeals: New Appeals Rule Will Make You Dizzy With Complex Procedures

Decide in advance what kind of representation to offer

Appealing claims next year could become simpler and quicker in some ways - and harder in others.

The **Centers For Medicare and Medicaid Services** published an interim final rule in the March 8 Federal Register spelling out how the agency will carry out all appeals changes in the Medicare Modernization Act and earlier laws. For instance, the new regulation says all second-level appeals for Part A and Part B will go to Qualified Independent Contractors (QICs) instead of fiscal intermediaries or carriers.

Also, the rule will move the Administrative Law Judges (ALJs) from the **Social Security Administration** into the **Dept. of Health and Human Services** - a move that observers worry could reduce the judges' independence from Medicare officials. Another consideration: you won't be able to introduce any new information at stages after the initial appeal.

Quickening the pace: The new rule also will shorten time frames. A "redetermination" by the QICs will take only 60 days (instead of 120 days), after which the provider has 180 days (instead of 6 months) to appeal that decision. ALJs and the next level, the Departmental Appeals Board, each will have only 90 days (instead of an unlimited time) to make a decision.

"On the surface it seems like [these] would be good changes," says **Tammy Tipton,** president of **Appeal Solutions** in Blanchard, OK. But providers won't really be able to tell if there are benefits until the changes take effect, she adds.

Watch out: One detail in the regulation could make your life way more complicated, says **Jin Zhou**, president of **ErisaClaim.com.** The regulation forces providers to choose between two different roles in an appeal: you can be the beneficiary's "appointed representative" or "authorized representative." If you're appointed, you need to obtain the patient's specific approval for each item you appeal. If you're authorized, you have the same rights as the beneficiary where appeals are concerned. But if you don't appeal "diligently" and then lose, you won't be able to collect any money from the beneficiary, Zhou says.

Plan of action: If you suspect services may not be payable, you should appeal as the appointed beneficiary so you can bill the patient afterwards. But if you know the patient won't be able to pay at all, go ahead and appeal as the authorized beneficiary, Zhou advises. Medicare will have standard forms to let you sign up as either type of representative.