Part B Insider (Multispecialty) Coding Alert

Part B Appeals: Stay on Top of the Part B Appeals Process With These Quick Tips

Five steps may separate you from suffering a denial and forfeiting your due reimbursement

The government may be having trouble meeting appeals deadlines, but you-re still expected to keep track of them.

A new OIG report revealed that Medicare's Qualified Independent Contractors (QICs) had trouble meeting deadlines (see related story on page 201), but that excuse will be little help if you fail to meet your own appeals deadlines.

Follow these quick tips to ensure that your claims are on track, and you-ll be in the clear if the QIC ever tries to claim that you didn't follow the process guidelines to the letter:

According to MLN Matters article MM4019, you should meet the following time requirements in your appeals process:

First step: During redetermination, you must appeal to your contractor within 120 days from the date you received your original denial.

Next step: If your claim is denied during redetermination, the next step is "reconsideration." You must file your reconsideration to the QIC within 180 days from the date you received the redetermination denial.

Third step: You can appeal at the administrative law judge (ALJ) level if at least $110 remains in controversy. During this step, you should file your appeal within 60 days from the day you received your reconsideration denial.

Fourth step: If the ALJ denies your appeal as well, you can appeal to the department appeals board (DAB) within 60 days of receiving the ALJ denial letter.

Fifth step: Finally, you can request a judicial review within 60 days of the day you received your DAB denial. You can only appeal at the judicial review level if at least $1,090 remains in controversy.

For a chart with these timelines and more information, visit
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf

CMS May Consider "Good Cause"

Extensions: CMS allows extensions to the time limits if you can show "good cause" for late filing, ac-cording to Chapter 29 of the Medi-care Claims Processing Manual.

Example: If the contractor sent you incorrect information about your claim and that caused a delay in you filing an appeal, CMS might consider that good cause, the Claims Processing Manual notes. In addition, other "unavoidable circumstances" would qualify as well, such as a flood at your office that precluded you from filing the appeal.

To read about the process for "good cause" appeal delays, go on-line to
http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf.