Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Must-Know Steps Keep You Ahead Of Appeals Process Changes

Medicare will now dismiss all incomplete appeals--but you have 3 options for addressing a dismissal

You might think you know the Medicare appeals process like a well-worn path, but starting Jan. 1 you'll have some new twists and turns to navigate.

"Medicare has a specific five-step formalized appeal process which is changing as of Jan. 1, 2006 for physician billing," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME** of CRN Healthcare Solutions in Tinton Falls, NJ. The changes--such as minimum amounts necessary for an appeal, timeframes, authorities and methods of decision notification--aren't drastic, but could cost you both time and money if you don't stay sharp.

Because you spend most of your time doing battle within the first two levels of the appeals process, you should prepare to navigate those levels in 2006 with the following four easy steps.

1. Understand Reopening

After your carrier has made an initial determination, the claim can be reopened to correct minor errors, Cobuzzi says. Reopening serves as an informal first step in the appeal process and has been a "long-standing source of confusion."

Why: Usually carriers reopen a claim for minor problems--such as a missing modifier, incorrect patient information or a missing UPIN for the referring physician, Cobuzzi says. You will usually reopen a claim over the phone, she adds.

Remember: If your carrier agrees to reopen a claim, you need to make the specified changes--but this does not constitute an appeal for carrier review. The errors each carrier accepts for reopening will vary, but the **Centers for Medicare and Medicaid Services** requires that carriers provide a reopening process. So if your carrier refuses, refer them to this new CMS guideline.

Example: Suppose you file a claim for an injection (90772) and a level-three established patient E/M service (99213) on the same day, but you fail to append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to **CPT 99213** . You'll receive a denial during the initial determination phase. You can call and reopen the claim, add the modifier 25 and hope the carrier will pay your claim via the reopening process, Cobuzzi says.

2. Know The Basics Of Redetermination

CMS formerly referred to the first level of the appeal process as "Post Payment Review" or "Carrier Review," but in 2006 this level will be known as "Redetermination," says **Steven Verno, NREMTP, CMBSI**, director of reimbursement for **Emergency Medicine Specialists** in Hollywood, FL.

Redetermination "is the only level that includes the carrier that initially denied or underpaid the claim--all other levels include independent review," Cobuzzi points out.

Timeframe: You must file a request for redetermination within 120 days of the initial denial or underpayment (receipt of the Explanation of Benefits [EOB]), Verno says. The 120-day timeframe has been in effect since July 31, 2002 per the Benefits Improvement and Protection Act (BIPA).

Form: Use Form CMS-20027 for all redetermination requests. You can find all necessary CMS appeal forms online at

www.cms.hhs.gov/forms.

Action: There is no minimum dollar amount required to file a redetermination request, so you can and should file one for every denied or underpaid claim that deserves full reimbursement.

Heads up: Your carrier will now notify you of the redetermination decision within 60 days using a Medicare Summary Notice (MSN), regardless of the outcome, Cobuzzi says. Under the old appeal system, carriers only informed you of an unfavorable outcome with a MSN, and informed you of a favorable outcome by sending your money on a Remittance Advice, she adds.

Additionally, redetermination notices will now identify missing documentation that you must submit if you wish to pursue the claim to the next level of appeal, Cobuzzi says.

3. Take The Next Step: Request Reconsideration

If your carrier hands down an unfavorable redetermination decision, you'll want to proceed to level two of the appeals process by requesting a "Reconsideration" (formerly known as a "Fair Hearing"). A Qualified Independent Contractor (QIC) is in charge of all reconsideration requests and, as with redeterminations, there is no minimum amount necessary to file a request, Verno says.

The QIC level is "an independent, on-the-record review of the claim in the context of the written CMS rules, carrier-specific memorandum and policies, and national policy in evaluating the merit of an appeal," Cobuzzi explains.

Timeframe: CMS mandates that you file a request for reconsideration within 180 calendar days from the date you receive the notice of redetermination.

Form: You must make a reconsideration request using standard Form CMS-20033. Remember to send a request for reconsideration to "the address indicated on the notice of redetermination," Cobuzzi says.

Important: The evidence you submit for reconsideration is all that CMS will allow you to submit throughout the rest of the appeal process. If you decide to pursue your claim to a higher level of appeal, you can't add any additional evidence to strengthen your case except in rare circumstances, Cobuzzi warns.

Medical necessity: If the carrier denied your claim because it says there was no medical necessity for the service, a level-two appeal will hopefully solve your problem. For issues of medical necessity, "the QIC is supposed to involve a panel of physicians" and base the final decision on clinical experience, the patient's medical records, and medical, technical and scientific evidence, Cobuzzi explains. If you receive a decision in your favor, however, don't think that the ruling will apply to similar claims in the future. CMS clearly states that a QIC ruling for medical necessity does not set a precedent.

4. Use 1 Of 3 Strategies To Tackle Dismissals

In the past, if your carrier determined that you filed an incomplete request for redetermination, it would return the request as incomplete. No more. Now the carrier will dismiss the incomplete request. If this happens, you have three possible courses of action, Cobuzzi says:

1. Request reconsideration by a QIC. If you believe your appeal was complete and ready for payment, you may request that a QIC reconsider the dismissal. You must file such a request within 60 days of dismissal notification. Caution: Doing so renders final decisive action. If the QIC rules in your favor, the carrier must reopen and process the appeal. But if the QIC decides the carrier's dismissal was valid, the decision is not subject to further review and you can do nothing more to pursue payment of your claim.

2. Ask your carrier to vacate the dismissal. If you can establish good cause for the carrier to reopen a dismissal and offer a new decision, then you can request that the carrier vacate the dismissal. You must file this request within six months of receiving the dismissal. The key here is to have very convincing evidence, as the carrier must determine that there is sufficient cause to vacate.

3. Re-file the claim. The filing period to submit an appeal for redetermination is 120 days from receipt of the EOB. If you have time left within this period, you can simply re-file the claim, and the carrier will vacate the dismissal and reopen your claim.