



Appeals

Published July 2010



Part B



IMPORTANT



The information provided in this manual was current as of June 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after January 2010 are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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RESUBMIT, REOPEN OR APPEAL?

Many times, providers are unsure of which steps to take to correct a Medicare claim. The task of staying abreast of Medicare policies and regulations can be overwhelming and providers may be uncertain regarding which process is correct. A common question is, "When should a provider resubmit a claim, request a reopening or begin an appeal process?"

Background

CMS and TrailBlazer Health Enterprises® strive to reduce costs and administrative waste in the Medicare program; therefore, an editing process was implemented for assigned claims. Analysis data show that since implementation, this process has saved millions of dollars for the Medicare Trust Fund.

RESUBMIT

The current editing process returns paper or electronic claims to the provider as unprocessable if the claim contains certain incomplete or invalid information.

When a claim is rejected as unprocessable (message CO-16) because certain information is missing/incomplete, the claim **may not** be appealed. Payment can only be considered once the claim is resubmitted with the omitted information.

When to Resubmit

There are specific identifiers that signal when a claim must be submitted as new. They are:

- A Medicare Remittance Advice (MRA) message of CO-16 appears. The CO-16 message is a general message code that indicates certain information is missing/incomplete.
- Along with the CO-16 message there will be a second message listed detailing what information is missing.
- The MRA legend/glossary will explain the claim has no appeal rights.

Some examples of rejected claims that should be resubmitted as new claims are:

- **Invalid** procedure codes and/or ICD-9-CM codes.
- **Incomplete** information, such as:
 - Billing provider primary identifier (NPI).
 - Drug name and/or dosage.
 - Operative reports (certain modifiers require a report).
 - Invalid Health Insurance Claim Numbers (HICNs).
 - Services payable by a primary insurer.

Note: This is not an inclusive list.

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Paper Claims

If resubmitting the claim on paper:

- Do not attach the remittance advice to the claim.
- Do not indicate/stamp “resubmit,” “second request,” “corrected claim,” etc., on the claim.
- Do not send these claims to any Medicare correspondence areas.

Reminder: Mandatory electronic claims filing still applies when resubmitting.

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REOPEN

Background

Section 937 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) required contractors to establish a process (effective January 1, 2006) for the correction of minor errors and omissions.

Minor Errors and Omissions

There is no need to appeal a claim if the provider made a minor error or omission (clerical error) in filing a claim. Providers can request TrailBlazerSM to reopen the claim so the clerical error can be corrected. A request for a reopening can be made via telephone, fax or mail.

What Claims Are Eligible for a Reopening?

The types of errors that **can** be corrected through the clerical error reopening process are:

- Changes to the number of services/units (increases only).
- Procedure code changes (higher codes only).
- Billed amount changes.
- Dates of service changes.
- Place of service changes.
- Omitted services due to contractor error.
- Omitted services due to provider error (only for services that cannot be filed alone and are now being submitted).
- Claim denied because the HIC number was missing or incorrect.
- Adding or deleting the following specific modifiers: 25, 26, 50, 57, 76, 77, GV, GW, LT, RT and TC.

Note: This is not an inclusive list. There may be instances where an issue cannot be resolved during a telephone reopening process. If the issue is too complex or additional medical documentation is needed from the provider, the telephone representative may elect to inform the caller that a written request for a redetermination or reopening must be submitted.

The following is a list of examples that are generally **inappropriate** for a reopening:

- Request submitted with notes or records.
- Additions or corrections to some modifiers.
- An in-depth review is required.
- The need for additional documentation.

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- Limitation of liability (waiver issues) that results in reversing a party's liability.
- Overpayment disputes or protests.
- Diagnosis code corrections/additions. (Diagnosis code corrections will no longer be accepted on the telephone reopening line. Diagnosis code changes are generally complex in nature and require in-depth research, so a written request should be submitted for these types of corrections.)
- Overpayments.
- The need for complex overpayment calculations or offsets.
- Medical necessity reductions.
- Review of operative reports, office notes, lab/path reports.
- The need for medical staff input.
- An initial determination date that is more than one year prior to the request for a reopening.
- Provider number corrections.
- Ambulance claims corrections.
- Chiropractic claims corrections.
- Multiple surgery pricing situations.
- Medically Unlikely Edits (MUEs).
- KX modifier.

Important Notes:

- Items/services that were not previously submitted cannot be added through the reopening process, other than those procedures that cannot be filed alone (e.g., mammogram add-on codes).
- Reopenings can be performed for clerical error corrections at the contractor's discretion. There may be situations where the representative (telephone or written) will inform the provider to request a redetermination.
- **A reopening is not an appeal right. However, providers can appeal a reopening decision.**
- If the deductible has been applied on the claim being reopened, it should be submitted as a written reopening request. (Providers should use the correct Part B Reopening form.)
- Any changes resulting in overpayments may not be handled as reopenings.

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Telephone Reopenings

There is a limit of three claim reopening adjustments per call. If a provider has 25 or more requests for the same reason, it is possible an express adjustment can be performed (see section titled, “Express Reopening Adjustments”).

The telephone reopening telephone number for Colorado, Oklahoma, New Mexico and Texas providers is:

(866) 865-5458
Monday – Friday, 8 a.m. – 4 p.m. CT

Note: Currently, TrailBlazer does not provide a telephone reopening number for Virginia providers.

What Is Needed to Request a Telephone Reopening?

When requesting a telephone reopening, the caller must provide:

- Provider name, Provider Transaction Access Number (PTAN), National Provider Identifier (NPI) and Tax Identification Number (TIN).
- Beneficiary name.
- Health Insurance Claim Number (HICN).
- Dates of service at issue.
- The specific services or items for which the reopening is being requested.

Providers should have their information ready at the time of the call. This will expedite the telephone reopening process.

Express Reopening Adjustments

To correct clerical errors on 25 or more claims for the same reason, providers should be familiar with the express adjustment process:

- Let the Customer Service Representative (CSR) know the request is for an express adjustment because there are 25 or more of the same situation.
- The CSR will take the information from the provider and the request will be handled through this process.
- Have specific information ready, including dates of service, processed dates, procedure codes, billed amounts, modifiers, provider number and Medicare Remittance Advice (MRA) check number.
- Depending on the situation, the CSR will take the information at the time of the call or instruct the caller to fax his information to a specific fax number.
- **Requests for express adjustments will be placed in date received order and processed within 60 calendar days of receipt.**

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Faxed Reopening Requests

Providers are able to fax their reopening request(s) to TrailBlazer utilizing the fax numbers shown below. Providers are encouraged to use the correct fax number specific to their state.

Colorado.....(469) 372-7705
New Mexico.....(469) 372-7704
Oklahoma.....(469) 372-7707
Texas(469) 372-7749
Virginia(469) 372-7785

Mailed Reopening Requests

Providers have the option to mail their reopening request(s) to TrailBlazer utilizing the correct address designated by state. It is very important for providers to pay close attention regarding appropriate reopening addresses.

Colorado, New Mexico, Oklahoma	Texas	Virginia
Part B Reopenings P.O. Box 650714 Dallas, TX 75265-0714	Part B Reopenings P.O. Box 660156 Dallas, TX 75266-0156	Part B Reopenings P.O. Box 660103 Dallas, TX 75266-0103

Medicare Part B Reopening Request Form

Whether providers elect to fax or mail their reopening request(s), TrailBlazer encourages the use of the Part B Reopening Request Form. It is an interactive, user-friendly tool that can be viewed online. Providers can easily access the form on the TrailBlazer Web site, type information in the appropriate sections and print the desired copies.

- The Part B Reopening Request Form does not contain a section for the name and signature of the requester. This information is not required for a reopening request.
- Do not mail this form for a redetermination/appeal request.
- Do not use this form for general or Medicare Secondary Payer (MSP) inquiries.

The TrailBlazer Medicare Part B Reopening Request Form can be viewed, completed and/or printed at:

<http://www.trailblazerhealth.com/Publications/PDF/Form/PartBReopeningRequestForm.pdf>

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Note: Along with the required information, it is acceptable to include a copy of the MRA with the specific claim/patient information highlighted, although it is not mandatory. Be very specific when requesting a written reopening.

Miscellaneous

- Health Professional Shortage Area (HPSA) bonus:
 - The TrailBlazer Reopening Request Form **must** be used when requesting adjustments for a (HPSA) bonus. (The Redetermination Request form **should not** be used for these types of requests.)
 - When mailing multiple requests for HPSA bonus adjustments, each provider is encouraged to send **one** Reopening Request form and attach a spreadsheet reflecting the to/from dates or paid date range. **(TrailBlazer would not expect to see a separate request form for each patient.)**

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APPEALS

Definition

An appeal is a written request to Medicare to reconsider a claim.

Background

The purpose of the appeals process is to give dissatisfied providers and beneficiaries a vehicle to request an independent re-evaluation of Medicare's claim decision. Through this process, Medicare seeks to ensure that the correct payment is made and a clear and adequate explanation is given supporting non-payment.

The appeals process utilizes the pertinent Medicare laws, provider documentation and patient record regarding the claim. Each level of appeal must be completed before proceeding to the next level. For example, an Administrative Law Judge (ALJ) review may not be requested until after the claim has completed redetermination and reconsideration reviews.

Who Can Appeal?

- Beneficiaries and their representatives.
- Medicaid state agency.
- A provider who has accepted assignment on a claim.
- The provider for certain non-assigned claims (for example, one who has accepted assignment with respect to items or services furnished to a beneficiary, but only for those items or services billed on an assigned basis).

Note: If the physician requests an appeal, the beneficiary does not lose his right to appeal the claim.

Filing a Request for Redetermination on Behalf of the Beneficiary

For written redeterminations requests filed on behalf of the beneficiary, there are special rules. These policies are defined in the Internet-Only Manual (IOM) Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, Section 310.1:

<http://www.cms.gov/manuals/downloads/clm104c29.pdf>

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Five Levels of Appeals

- Redeterminations.
- Reconsiderations.
- ALJ.
- Medicare Appeals Council (MAC) review (part of the Departmental Appeals Board).
- Judicial review in U.S. District Court.

Redeterminations

Our Mandate

The Medicare contractor is mandated to complete redeterminations within 60 days of receipt. The redetermination notice must be mailed to the parties within this 60-day period.

To process a redetermination as quickly as possible, all documentation relevant to the request should be filed. Otherwise, a redetermination will be made based on the information at hand.

Written Redetermination Requests and the Medicare Part B Redetermination Request Form

Written redetermination requests may be submitted on Form CMS-20027 or the TrailBlazer Medicare Part B Redetermination Request Form. This form is an interactive, user-friendly tool that can be viewed on the TrailBlazer Web site. Providers can easily access the form, type information in the appropriate sections and print the desired copies. ***A signature on either form is mandatory!***

If neither form is used for a written redetermination request, the request must be submitted with all the following:

- Beneficiary name.
- Beneficiary's Health Insurance Claim Number (HICN).
- Dates of service at issue.
- The specific services or items for which the redetermination is being requested.
- Name and signature of the party or representative of the party.
- Provider information such as Provider Transaction Access Number (PTAN), National Provider Identifier (NPI) and Tax Identification Number (TIN). (This is not needed if the provider sends the Medicare remittance with the request.)

At this time, redeterminations may not be faxed to TrailBlazer.

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Providers may obtain the Form CMS-20027 from the CMS Web site at:

<http://www.cms.gov/cmsforms/downloads/cms20027.pdf>

The TrailBlazer Medicare Part B Redetermination Request Form can be viewed, completed and/or printed at:

<http://www.trailblazerhealth.com/Publications/PDF/Form/PartBRedeterminationRequestForm.pdf>

Individual Consideration Process for Local Coverage Determinations (LCDs)

Certain unusual frequencies or uses of the service/procedure may be described in a Local Coverage Determination (LCD). Individual consideration may be given for situations that are consistent with that described in the LCD article titled “LCD Individual Consideration Instructions.” This will be a process to use when there is a service that would rarely be used for a Medicare beneficiary.

For Medicare to provide LCD Individual Consideration, the words “**LCD INDIVIDUAL CONSIDERATION REQUEST**” must be present on the Redetermination Request form. Also required with the redetermination request are medical records demonstrating that the circumstances of the patient’s condition meet the requirements for coverage under the LCD.

This is not intended to be a generic process for all LCDs – only those specifically identified LCDs that include the “Individual Consideration” language.

Time Limit

A request for a **redetermination** must be received by the Medicare contractor within 120 days from the date of the initial determination. (The date will appear in the top right-hand corner of the remittance advice.)

- TrailBlazer effectuates the claim if the denial is reversed and the claim is paid or partially paid. Payment will be sent with a Medicare Remittance Advice (MRA).
- If payment is not made or the decision is not reversed, the provider will receive a letter outlining the action taken and instructions for the next appeal level.

Monetary Threshold

There is no monetary threshold to meet.

For Requests Filed in Writing

The date received is defined as the date the Medicare contractor receives the request in its corporate mailroom.

For Requests Filed in Person

The date received is defined as the date of the office’s date stamp on the request.

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Reminders

- Redetermination requests lacking required items **are not** returned to the provider. If any required item is missing, the redetermination request will be dismissed. The provider will be notified of the dismissal in writing.
- **Do not mail the Part B Reopening Request Form for a redetermination. If TrailBlazer receives this form, it will be returned and the appeal may be delayed. The time limit is critical!**
- Do not use adhesive notes in submitting a redetermination request.
- Type the redetermination forms or print legibly using a black or blue pen.
- Submit all supporting medical documentation with the request.
- Make sure the forms are signed and dated by the appropriate person.
- Review the form completely before mailing.

Redetermination Addresses

Based on the provider's practice address, providers should mail redeterminations to the addresses below. Correct address usage will expedite an appeal request.

Colorado, New Mexico, Oklahoma	Texas	Virginia
Part B Redeterminations P.O. Box 650714 Dallas, TX 75265-0714	Part B Redeterminations P.O. Box 660156 Dallas, TX 75266-0156	Part B Redeterminations P.O. Box 660103 Dallas, TX 75266-0103

Correct and Timely Response

To ensure a correct and timely response, physicians/suppliers should:

- Submit a complete form (CMS-20027 or the TrailBlazer Medicare Part B Redetermination Form).
- Return a copy of the remittance advice (and claim, if possible).
- Be specific, identifying the service(s) in question and the need for the redetermination. Don't use the general phrase "please review" unless every service on the claim is in question.
- Provide any additional information needed with the redetermination request (i.e., operative report, description of service, name and dosage of drug, etc.).
- Sign the request.

Note: In situations where a provider requests an appeal and the issue involves a minor error or omission, TrailBlazer will treat the request as a request for a reopening.

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Remittance Advice

When making an adjustment to claim information as a result of a reopening or redetermination, the original claim information is voided and replaced by the corrected data as if it were a new claim. Any original payment must be offset against other benefits due. Therefore, changes have been made to the information that is shown on provider remittance advices for adjusted claims.

When a claim is adjusted as a result of a redetermination or reopening, the remittance advice will include all services on the original claim even if only one service was adjusted. The amount shown in the ALLOWED column will be the entire allowed amount for the service, and the amount shown in the PROV PD column will show the entire amount paid for the service, including any payment made on the original claim. The Total PROV PD amount less the PREV PD amount will equal the NET amount. The NET amount will be the additional payment the provider receives with his remittance advice.

Educational Resources

CMS Web Site

IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29:

<http://www.cms.gov/manuals/downloads/clm104c29.pdf>

The TrailBlazer Web site offers many educational resources regarding the appeal process including:

- Frequently Asked Questions (FAQs).
- Job aids.
- Notices.

Providers may click on the Appeals Web page to access these educational resources:

<http://www.trailblazerhealth.com/Appeals/Default.aspx>

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MEDICARE

PROVIDER #: #####

ANYTOWN LIVING WELL FAMILY PRACTICE

REMITTANCE

CHECK/EFT 8XXXXXXXXX

11/16/09

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NOTICE

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	DOE, JOHN		HIC	#####X#	ACNT	AAAAAAAAAAAAAAAAAAAA	ICN	2809XXXXXXXXXX	ASG	Y	MOA	MA01 MA07
#####	1026	102609	11	1	G0180		80.00	48.46	0.00	9.69	CO-42	31.54 38.77
PT	RESP	9.69			CLAIM TOTALS		80.00	48.46	0.00	9.69		31.54 38.77
CLAIM INFORMATION FORWARDED TO: TEXAS MEDICAID												
38.77 NET												

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	6	779.88	438.02	0.00	86.99	341.86	351.02	0.00	351.02

GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes

CO Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.

PR Patient Responsibility. Amount that may be billed to a patient or another payer.

OA Other Adjustment.

B7 This provider was not certified/eligible to be paid for this procedure/service on this date of service.

100 Payment made to patient/insured/responsible party.

23 Payment adjusted because charges have been paid by another payer.

42 Charges exceed our fee schedule or maximum allowable amount.

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

MA07 The claim information has also been forwarded to Medicaid for review.

MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

Note the "MA01" remark code on the MRA legend. This message explains the next step when requesting a redetermination.

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Reconsiderations

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869 of the Social Security Act (the Act), as amended by BIPA, requires a second level in the administrative appeals process called a reconsideration.

Regulations require that appellants dissatisfied with a redetermination can request a reconsideration. A signed request with written expression of dissatisfaction must be received within 180 days of the date of receipt of the redetermination. There is no monetary threshold to be met. Reconsiderations will be processed by the Qualified Independent Contractor (QIC).

Qualified Independent Contractors (QICs)

What Are QICs?

QICs are companies that will perform the second level of appeal for Medicare fee-for-service claims. They will conduct a reconsideration of a Medicare Part B appeal.

QIC reconsiderations offer:

- Faster reconsideration time frame. A QIC reconsideration must be completed within 60 days (with optional escalation).
- Panel of health professionals' review. If the denial was based on medical necessity, the QIC must have a panel of physicians or other health care professionals with the appropriate clinical expertise to review a claim.
- Detailed information in the decision letter. The QIC must include a detailed explanation of the decision, including any pertinent facts and applicable regulations and, in the case of a medical necessity denial, an explanation of the medical and scientific reason for the decision.

Time Limit

The time limit for requesting a reconsideration is 180 days from the date of the redetermination letter.

Monetary Threshold

There is no monetary threshold to meet.

Provider Requirements for a Reconsideration Request

Requests must be in writing in one of the four formats listed below:

1. Written request on a Form CMS-20033.
2. Written request on a TrailBlazer Part B Reconsideration Request Form.
3. On a completed Reconsideration Request Form included with your

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redetermination letter.

Or,

4. In another written format containing all of the following items:
 - The beneficiary's name.
 - Medicare HICN.
 - The specific service(s) and item(s) for which the reconsideration is requested.
 - Specific dates of service.
 - The name and signature of the party or representative of the party.
 - The name of the contractor that made the redetermination.

To Request a Reconsideration

Send the request for a QIC reconsideration to:

Colorado, New Mexico, Oklahoma, Texas and Virginia QIC:

**Q² Administrators, LLC
Part B QIC East Operations
P.O. Box 183092
Columbus, OH 43218-3092**

Form CMS-20033 may be downloaded from the CMS Web site at:

<http://www.cms.gov/cmsforms/downloads/cms20033.pdf>

The TrailBlazer Part B Reconsideration Request Form may be found at:

<http://www.trailblazerhealth.com/Publications/PDF/Form/ReconsiderationRequestFormPartB.pdf>

Administrative Law Judge (ALJ)

Background

Regulations require that appellants dissatisfied with a QIC decision have a right to a hearing by an ALJ. *ALJ hearings are generally held by Video Teleconference (VTC) or by telephone. If a provider does not want a VTC or telephone hearing, he may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing, and the ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Appellants may also ask the ALJ to make a decision without a hearing (on-the-record).*

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Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after notifying all parties to the hearing.

Time Limit

An ALJ hearing must be requested within 60 days of the date of the QIC decision.

Monetary Threshold – Amount in Controversy

For an ALJ hearing, the amount in controversy for initial determinations made on or after January 1, 2010, must equal or exceed \$130. (Previous amount in controversy was \$120.)

How amounts in controversy are calculated and the aggregation of claims to meet the amounts in controversy can be found in the Internet-Only Manual (IOM), Pub. 100-04, Chapter 29.

<http://www.cms.gov/manuals/downloads/clm104c29.pdf>

Medicare Appeals Council (MAC)

If a provider is still dissatisfied with the ALJ decision, he may file a request for a review with the DAB within 60 days of receipt of the ALJ decision/dismissal. A MAC has 90 days to accept or reject the case referred.

Monetary Threshold

The monetary threshold is \$0; however, providers are unable to proceed to the next level unless the amount in controversy is \$1,260 or more. (Previous amount in controversy was \$1,180.)

Judicial Review in U.S. District Court

The final level of appeal must be filed within 60 days of receipt of the MAC decision or declination of review by the MAC to the federal court review.

Effective January 1, 2010, the amount in controversy changed to \$1,260.

How amounts in controversy are calculated and the aggregation of claims to meet the amounts in controversy can be found in the IOM, Pub. 100-04, Chapter 29.

<http://www.cms.gov/manuals/downloads/clm104c29.pdf>

The review must name the Secretary of Health and Human Services as the defendant and must be filed in the same district in which the beneficiary resides.

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Appeals Process – Quick Chart

Appeal Level	Time Limit for Filing Request	Monetary Threshold to Be Met
1. Redeterminations	120 days from the date of receipt of the initial determination notice	None
2. Reconsiderations	180 days from the date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	Effective January 1, 2010, the amount in controversy required to request an ALJ hearing increased to \$130.
4. Medicare Appeals Council (MAC) Review (part of the Departmental Appeals Board (DAB))	60 days from the date of receipt of the ALJ hearing decision	None
5. Judicial Review in U.S. District Court	60 days from the date of receipt of DAB decision or declination of review by DAB	Effective January 1, 2010, the amount in controversy required to request a judicial review increased to \$1,260.

Providers may download and print the Quick Chart for a desk reference at:

<http://www.trailblazerhealth.com/Publications/Job Aid/appeals quick reference.pdf>

Claims Appeals – Flow Chart

<http://www.trailblazerhealth.com/Publications/Job Aid/Part B Claims Redeterminations Process.pdf>

Miscellaneous

- Providers have the same appeal rights for Comprehensive Error Rate Testing (CERT) as they do for any other claim since all the same Medicare guidelines apply. A request for an appeal based on a CERT error should be made to the MAC.

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- Providers have the same appeal rights for the Recovery Audit Contractor (RAC) decisions as they do for any other claim since all the same Medicare guidelines apply. A request for an appeal based on an RAC overpayment/underpayment should be made to the MAC.

For more information about the RAC, its appeal processes and the "discussion period," visit the CMS and Connolly Healthcare Web sites at:

- <http://www.cms.gov/RAC/>.
- http://www.connollyhealthcare.com/RAC/pages/cms_RAC_Program.aspx.

Frequently Asked Questions (FAQs)

Q. If I want to send a corrected claim, do I need to appeal or just resubmit the claim with the correct information?

A. It depends on the situation.

- If the CMS claim form is returned to the provider's office with a cover letter explaining what is missing, the corrected claim must be refiled to the Medicare contractor. (In this situation, the claim has never been entered into the Medicare claims processing system; therefore, it does not have appeal rights.)
- If a claim is rejected and the provider's Medicare Remittance Advice (MRA) indicates message MA-130, "Your claim contains incomplete and/or invalid information and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information," the provider must submit a corrected claim for processing.

Q. Instead of appealing a claim that has been denied for medical necessity, may I resubmit as a corrected claim?

A. A provider can resubmit any denied claim. He may choose to submit additional information that was not reported on the original claim (correction to number of units, etc.). The new claim could possibly pay or deny for a different reason.

However, if records were requested by medical staff at the initial claims processing level **and** the determination was based on those reviewed records, a corrected claim should be appealed instead of submitting it as a new claim. **Note:** A medically denied Part B claim is not subject to a reopening (correction to a minor clerical error or omission).

Q. How do I check status on my appeal?

A. A provider can call the Provider Call Center (PCC) and state that he is calling for a status of his redetermination. Although Customer Service Representatives (CSRs) will not be able to offer payment details, they can offer the following information, depending on the situation:

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- **Favorable** – CSR can reveal to the caller if the appeal was received and/or if there is an adjustment processing or has already processed.
- **Unfavorable** – CSR can reveal to the caller if the appeal request was received and resulted in an unfavorable decision. The caller will be referred to the unfavorable decision letter and date of the letter.

Q. If an appeal has been requested and the 60 days have long passed, what is my next step?

A. Providers can call the PCC. All contact numbers and addresses are found on the TrailBlazer Web site at: <http://www.trailblazerhealth.com/Tools/Contacts.aspx>.

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REVISION HISTORY

Date	Section	Revision
July 2007	Appeals	<ul style="list-style-type: none"> Added the Appeals Web page link for additional educational resources. Removed outdated information under the “Federal Court” subtitle.
January 2008	Appeals	<ul style="list-style-type: none"> Resubmit, Reopen or Appeal? – added introduction. What is Needed for a Reopening – revised language. Five Levels of Appeals - changed Department of Appeals Board to read Medicare Appeals Council (MAC). Written request requirements when CMS Form 20027 is not submitted – revised language. Medicare Remittance Advice (MRA) example – updated fee amounts and other miscellaneous information. Per JSM 08089- ALJ and Judicial Review in Federal Court monies updated. Appeals Process – Quick Chart – link to job aid.
December 2008	Resubmit, Reopen or Appeal?	<ul style="list-style-type: none"> Added Medicare Trust Fund background information.
	Resubmit	<ul style="list-style-type: none"> Updated and added detailed resubmission information.
	Reopen	<ul style="list-style-type: none"> Added background information. Updated the appropriate examples of reopening requests. Added reminders. Added a “Telephone Reopening” section. Added an “Express Reopening” section. Added fax numbers. Added addresses for mailed reopening requests. Featured the newly designed Medicare Part B Reopening Request Form.

MEDICARE PART B

Appeals

Date	Section	Revision
	Appeals	<ul style="list-style-type: none"> Updated background information in the “Appeals” section.
	Redeterminations	<ul style="list-style-type: none"> Featured the newly designed Medicare Part B Redetermination Request Form. Updated the language in the “Individual Consideration Process” section. Added bulleted information in the “Time Limit” section. Added monetary threshold information. Updated the reminders. Added the redetermination addresses. Added educational resources information. Updated the Medicare Remittance Advice (MRA) example.
	Reconsiderations	<ul style="list-style-type: none"> Added monetary threshold information. Deleted the Maryland and District of Columbia/Delaware QIC address. Added the link for the CMS-Form 20033.
	Medicare Appeals Council	Added monetary threshold information.
	Judicial Review in U.S. District Court	Added district court filing requirement.
February 2009	Administrative Law Judge (ALJ)	Per Change Request (CR) 6295, added background information for annual re-evaluation of the dollar amount in controversy. No change for 2009.
	Judicial Review	Added CR 6295 information announcing an amount in controversy increase to \$1,220 effective May 4, 2009.
	Medicare Remittance Advice (MRA)	Revised MRA. Deleted a claim and adjusted money amounts.

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Appeals

Date	Section	Revision
August 2009	Reopen	<ul style="list-style-type: none"> • Revised the appropriate types of clerical errors that can be corrected through a reopening. • Revised the hours of operation of the Telephone Reopening department. • Added the provider verification requirements needed for a telephone reopening. • Revised the fax numbers for New Mexico and Oklahoma reopenings. • Deleted “newly designed” references regarding the Medicare Part B Reopening Request Form. • Added note about incorrectly using the reopening form for other purposes.
	Appeals	<ul style="list-style-type: none"> • “Who Can Appeal?” section: Revised the definition for the provider of non-assigned claims. • Added language regarding filing a request for a redetermination on behalf of the beneficiary. • Deleted “newly designed” references regarding the Medicare Part B Redetermination Request Form. • Added sentence about the mandatory signing of the redetermination forms. • Added provider identification requirements for written redetermination requests not submitted on a form. • Educational Resources – added the CMS Web site link for the Medicare Claims Processing Manual. • Added link to the Claims Appeals – Flow Chart on the TrailBlazer Web site.
	MRA Example	Added note.
October 2009	Reopen	Revised the appropriate/inappropriate types of clerical errors that can be corrected through a reopening.
November 2009	Reopen	<ul style="list-style-type: none"> • Updated addresses for mailed reopening requests. • Added “Miscellaneous” section.

MEDICARE PART B

Appeals

Date	Section	Revision
	Appeals	<ul style="list-style-type: none"> • Revised Individual Consideration Process language. • Updated addresses for mailed redetermination requests. • Added an additional format under the “Provider Requirements for a Reconsideration Request” and numbered steps. • Updated the Medicare Remittance Advice (MRA). • Added a link to the TrailBlazer Part B Reconsideration Request Form. • Added “Miscellaneous” section.
December 2009	Reopen	Added the Virginia reopening fax number.
February 2010	Reopen	<ul style="list-style-type: none"> • Deleted the KX modifier from claims eligible for reopenings. • Added the KX modifier to the list of inappropriate examples of reopenings.
	Administrative Law Judge	Effective January 1, 2010, the amount in controversy changed to \$130.
	Medicare Appeals Council	<ul style="list-style-type: none"> • Added sentence about the amount in controversy to proceed to the next level.
	Judicial Review in U.S. District Court	<ul style="list-style-type: none"> • Deleted Change Request reference for old amount in controversy. • Added statement – Effective January 1, 2010, the amount in controversy changed to \$1,260.
	Appeals Quick Chart	Added the Appeals Quick Chart and updated the amounts in controversy.
	Miscellaneous	<ul style="list-style-type: none"> • Updated CERT appeal information. • Added RAC appeal information and Web links.
	Frequently Asked Questions (FAQs)	Added new section with common questions.

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Appeals

Date	Section	Revision
<i>July 2010</i>	<i>Administrative Law Judge (ALJ)</i>	<ul style="list-style-type: none"><i>Added language regarding the options for an ALJ (video teleconference or in-person).</i><i>Added reference about the calculation to determine the amount in controversy and the aggregation of claims.</i>
	<i>Judicial Review in U.S. District Court</i>	<i>Added reference about the calculation to determine the amount in controversy and the aggregation of claims.</i>
	<i>All sections</i>	<i>Updated CMS Web links.</i>