Acknowledgments

This resource was developed by the “Deciphering the Regulations” Task Force

Task Force of the Practice Committee of the Home Health Section

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Providers' Tips for avoiding the Appeal Process

- Know your regulations federal and state levels
- MACs have to publish their activity and will have the top reasons for denials
- Be prepared for an Additional Documentation Request (ADR)- know how to look to see if you have an ADR and check; possible signature log for every record; ask for the electronic policy from the Medical Doctor (MD)hospital etc. if you accept their electronic signature; and education to the staff on medical necessity, regulations, and proper documentation.
- Were the orders received before the services were rendered? Document MD approval to the POC and visit frequency for **EACH** discipline. Are you including proper content in your order?

Medicare Appeal Process

There are five levels in the claims appeal process under the Original Medicare entitlement and not the Medicare Advantage plans.

At any time, a party may appoint any individual, including an attorney, to represent him or her during the processing of a claim or appeal. The representative helps the party by providing assistance and expertise. You must complete Form CMS-1696 called, "Appointment of Representative." (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html)

If a claim contains a minor error or omission, the claim may be corrected through the reopening process rather than the appeals process. Consult this link to correct minor errors and omissions, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf

First Level of Appeal: Redetermination

1. First level of appeal after the initial determination on a claim. It is a second look at the claim.
2. You must file a request for redetermination **within 120 days** from the date of receipt of the Remittance Advice (RA) that lists the initial determination.
3. File request in writing by following instructions provided in the RA. Remember you, or your representative, must include your **name and signature**.
4. MAC staff unassociated with the initial claim determination performs the redetermination.

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5. MACs generally issue a decision within **60 days** of receipt of the request for redetermination. You will receive notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC.

Second Level of Appeal: Reconsideration

1. Disagree with the MAC redetermination decision you can request reconsideration by a QIC. Reconsideration is a review of the redetermination decision.
2. You must file a request for reconsideration **within 180 days** of receipt of the MRN.
3. File your request in writing by following instructions provided on the MRN. **Clearly explain** why you disagree with the redetermination decision. The representative must include your **name and signature. Submit 1)** Copy of the RA or MRN; **2)** Any evidence noted in the redetermination as missing; **3)** Any other evidence relevant to the appeal; and **4)** Any other useful documentation.
4. Documentation submitted after you file the reconsideration request may extend the Quality Improvement Organization's (QIO) decision timeframe.
5. NOTE: Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late.
6. Qualified Independent Contractor (QIC) conducts the reconsideration, which is an independent review of the redetermination. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals.
7. Generally, QICs send a decision to all parties within **60 days** of receipt of the request for reconsideration. If the QIC cannot complete its decision in the applicable timeframe, it will inform you of your rights and the procedures to escalate the case to an Administrative Law Judge (ALJ). May want to wait an additional 5-10 days for mail delays prior to escalating your appeal to an ALJ.

Third Level of Appeal: ALJ Hearing

1. If you disagree with the reconsideration decision, or you wish to escalate your appeal because the reconsideration period passed, you may request an ALJ hearing. The ALJ hearing gives you the opportunity, via video teleconference (VTC), telephone, or occasionally in person, to explain your position to an ALJ. The U.S. Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS, is responsible for the Level 3 Medicare claims appeals.

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2. To file a request for an ALJ hearing within 60 days of receipt of the reconsideration decision letter or after the expiration of the reconsideration period. There is a minimum Amount in Controversy (AIC) requirement and you may only request an ALJ hearing if a certain dollar amount remains in controversy following the QIC's decision. This threshold is updated annually. For current amount visit http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html on the CMS website.
3. File your request in writing by following instructions provided in the reconsideration letter. Alternatively, you may request an ALJ hearing by completing Form CMS-20034 A/B REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE. For the requirements for a written request, tips on filing an ALJ hearing request, or to access Form CMS-20034 A/B, (called Request for Medicare Hearing by an Administrative Law Judge), visit http://www.hhs.gov/omha on the HHS website.
4. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis. You may also ask the ALJ to make a decision without a hearing (on-the-record).
5. You must send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. If you are requesting the case be escalated to the Appeals Council, a copy of the request must be sent to all other parties **and** to the ALJ. The ALJ sets hearing preparation procedures. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing.
6. The ALJ makes the decision and if it cannot be completed in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Appeals Council. The ALJ forward the decision and case file to the Administrative QIC (AdQIC), which serves as the central manager for all ALJ Original Medicare claim case files. In certain situations, the AdQIC may refer the case to the Appeals Council on CMS' behalf. If no referral is made to the Appeals Council, and the ALJ decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC that it must pay the claim, according to the ALJ decision, within 30-60 days.
7. The OMHA oversees all Level 3 Medicare appeal hearings. Due to an overwhelming number of new requests and the existing workload, OMHA has delayed new requests received after April 1, 2013, for ALJ hearing assignments. OMHA will be processing ALJ hearing requests in the order received and as quickly as possible.
8. Due to a record number of appeal requests, if 22 weeks have not lapsed since your initial ALJ hearing submission request, do not resubmit your request. For more info on the timeframes,

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visit http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html on the HHS website.

9. Two pilot programs were implemented due to the number or requests and delays which are Settlement Conference Facilitation (SCF) and Statistical Sampling Initiative. SCF is an alternative dispute resolution process that uses medication principles. Statistical Sampling Initiative applies to appellants with a large volume of claim disputes. For more information, visit http://www.hhs.gov/omha on the OMHA website.

Fourth Level of Appeal: Medicare Appeals Council Review

1. If you disagree with the ALJ decision, or you wish to escalate your appeal because the ALJ ruling timeframe passed, you may request a Medicare Appeals Council review. You must file your request for Medicare Appeals Council review within **60 days** of receipt of the ALJ's decision or after the ALJ ruling timeframe expires. There is no Minimum AIC requirement for this level.
2. File your request in writing by following the instructions provided by the ALJ. Alternatively, you may request an Appeals Council review by completing Form DAB-101. **Remember to explain** which part of the ALJ decision you disagree with and your reasons for disagreement. You **must** send a copy of the Appeals Council review request to all the parties included in the ALJ's decision. If you are requesting escalation to U.S. District Court, a copy of the request must be sent to all other parties **and** to the Appeals Council. http://www.hhs.gov/dab/divisions/medicareoperations

10. The **Appeals Council** makes the decision. If the Appeals Council cannot complete its decision in the applicable timeframe, it will inform you of your right and procedures to escalate the case to U.S. District Court. The Appeals Council forward the decision and case file to the AdQIC, which serves as the central manager for all ALJ Original Medicare claim case files. If the Appeals Council overturns a previous denial (in whole or in part), the AdQIC notifies the MAC that it must pay the claim, according to the Appeal Council's decision, within 30-60 days.

3. Generally, the Appeals Council issues a decision **within 90 days** from receipt of a review of an ALJ decision. If the Appeals Council review stems from an escalated appeal, then the Appeals Council has **180 days from the date of receipt** of the request for escalation to issue a decision. A decision may take longer due to a variety of reasons. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Appeals Council to escalate the case to the judicial review level.

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Fifth level of Appeal: Judicial Review in U.S. District Court

1. If you disagree with the Appeals council decision, or you wish to escalate your appeal because the Appeals council ruling timeframe passed, you may request judicial review. You must file a request for judicial review within **60 days** of receipt of the Appeals Council's decision or after the Appeals Council ruling timeframe expires.
2. The Appeals Council decision (or notice of right to escalation) contains information on how to submit a claim in the U.S. District Court. The U.S. District Court will make the decision and has no statutory time limit to make the decision.
3. You may only request judicial review if a certain dollar amount remains in controversy following the Medicare Appeals Council decision. The AIC threshold is updated annually. For current amount, visit http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html on the CMS website.

Tips for Filing an Appeal

- Starting at Level 1, consolidate into one appeal as many similar claims as possible;
- File timely request with the appropriate contractor;
- Include a copy of the decision letter(s) issued at the previous level;
- Include a copy of the demand letter(s) if appealing an overpayment determination;
- Include a copy of the Appointment of Representative (AOR) form if representing a provider/supplier/beneficiary;
- Respond promptly to the contractor requests for documentation;
- Sign your request appeal
- Poor Documentation noted in the chart -- possibly look at adding attestations stating facts and signed with current date.
- Remember to check copies you are sending. Make sure signatures or part of the chart are not missing.

Medicare Appeal Processing Manual: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf

Medicare Learning Network (MLN) Guided Pathways: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf

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