

How to Appeal Decisions By Medicare Administrative Contractors

Under Medicare Part B, if you are denied payment for services you have provided to a Medicare beneficiary, or are not paid the full amount you believe you're entitled to, there is currently a very specific five-level appeals process established for you to follow.

The Contractor Redetermination

Within 120 days after the issuance of a Medicare claims decision that you feel is incorrect, you may request a **redetermination** of the decision that was made. Your written request should be sent to the Medicare Administrative Contractor (MAC) whose decision you are contesting. A request for a redetermination must be in writing. The most convenient way to do this is by using a Medicare Redetermination Request Form (Form CMS-20027), which can be accessed online at <http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf> or can be obtained from the APA's Office of Healthcare Systems and Financing by calling the Managed Care Help Line at 800-343-4671. Be sure to include your NPI number on the request form even though there is not a specific space for this. We suggest putting it on the line with your name. The form states that if you have evidence to submit it should be attached to the form. This means that any documentation you have supporting the claim should be copied and included with the form. You should receive the Medicare Redetermination Notice (MRN) within 60 days of your request.

If the decision you receive is unacceptable, you can move on to the next level of the appeals process. The MRN, which informs you of the MAC's decision, should also provide instructions on how to access the next level of appeal, reconsideration by a Qualified Independent Contractor (QIC). There are four QICs serving four geographical regions. The MRN will tell you which QIC serves your locale.

It is important to note that many MAC decisions are overturned at subsequent levels of appeal.

Reconsideration by a Qualified Independent Contractor (QIC)

After you receive notice of the MAC redetermination you have 180 days to request the next level of appeal, the **reconsideration by the QIC**. This request can be submitted to the appropriate QIC using a Medicare Reconsideration Request Form (Form CMS-20033), which can be found on the CMS website at <http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>, but you should also send a letter that explains in detail why you disagree with the redetermination decision the carrier made, provides a chronology of the patient's care (referring to where documentation is in the patient records you provided), and essentially makes your case that the redetermination should be reversed. You will also need to include any evidence/documentation the redetermination stated was missing as well as any other documentation you feel will help your case. The MRN you received with the denial of your redetermination will indicate where you should send the request to continue the appeals process. The QIC should send its decision to you within 60 days of receiving your request for reconsideration. If the decision is not favorable it will contain detailed information on the next level of appeal, the Administrative Law Judge (ALJ) Hearing. If the QIC is not able to make its decision in a timely manner, it will also inform you of your right to go on to the ALJ level. However, there must be at least \$110 in controversy for the appeal to be eligible for an ALJ Hearing. (This amount may be adjusted in future years. You can check with the APA's Managed Care Help

Line for the amount when you make your appeal, 800-343-4671.) If there is less money involved, the appeal process ends at the QIC level.

The Administrative Law Judge (ALJ) Hearing

Within sixty days after your receipt of the notice of the QIC decision, if there is at least \$110 in question, you can file a written request for an ALJ Hearing, using the instructions sent to you with that decision. There is a form that can be used to make this request, CMS-20034 A/B, which can be accessed at <http://www.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf>.

When filing for an ALJ Hearing, two or more physicians may aggregate claims to meet the dollar requirement if they involve the delivery of similar or related services to the same beneficiary or if the claims involve common issues of law and fact with respect to services provided to two or more beneficiaries. The only other stipulation is that all of these claims must have been subject to a Hearing Officer decision within sixty days of the ALJ Hearing request.

ALJ hearings are usually held via video-conference or by telephone. You may request an in-person hearing if you can establish good cause as to why the other methods won't do. If you wish, you may ask the ALJ to make a decision without a hearing—just on the basis of the written record.

ALJs are expected to issue decisions within ninety days of receiving the hearing request for standard appeals. However, as of July 2014 there is a huge backlog of cases waiting to be heard by an ALJ that some feel is the result of aggressive auditing by Medicare recovery auditors (RACs) that began in 2010. The requirement for an in-person hearing or the need for more evidence may delay things even further. As with the previous levels of appeal, the ALJ Hearing decision is binding on all parties unless there are further appeals or revisions of the decision.

Further Appeals

There are two levels of appeal that beyond the ALJ Hearing, the Medicare Appeals Council Review and the Federal District Court Hearing. The requirements for these appeals are complex and stringent, and you should consult with a healthcare lawyer or a practice consultant before considering going on to these levels of appeal.

Note: If you receive a notice from your Medicare Administrative Contractor stating that you owe Medicare money because on a postpayment review it was determined the claim should not have been paid, you have a right to appeal just as you would appeal a claim that is initially denied. Medicare cannot recoup the money they request while the appeal is in process, but should you lose, you will have to pay the amount owed as well as the interest that has accrued on the owed amount during the course of the appeal.