Take Five Steps to Appeal Medicare Part B Denials

BY MARY ELLEN SCHNEIDER
Senior Writer

LAS VEGAS — On Jan. 1, Medicare officials implemented a new five-step process for appealing Medicare Part B claims.

The changes apply to Part B initial claim determinations issued and mailed on or after that date, Edward R. Gaines III, senior vice president for compliance and general counsel at Healthcare Business Resources Inc. of Durham, N.C., said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

The new process includes some significant procedural differences that could benefit physicians, including an opportunity for an independent review earlier in the process, Mr. Gaines said in an interview. The new process includes these steps:

► **Step 1.** The process begins with a "redetermination" of the initial claim decision made by the Part B carrier. The redetermination is also made by the Part B carrier but the appeals decision is made by an employee who was not involved in the initial determination. This is the only step in the process that involves the Part B carrier that made the original decision, Mr. Gaines said.

Physicians have 120 days from the receipt of the notice of initial determination to file an appeal. Mr. Gaines recommended filing all documentation with the letter requesting a redetermination, including case summaries explaining your code selection. Otherwise, the carrier automatically receives up to 14 additional days to its 60-day decision deadline.

► **Step 2.** Providers can appeal the redetermination decision in a step called reconsideration. Physicians have 180 days from the date of receipt of the redetermination to file this appeal with the Qualified Independent Contractor (QIC) indicated in the Part B carrier letter.

The redetermination step replaces the old "fair hearing" process. The old process was frequently criticized since the fair hearing officer usually had close ties to the Part B carrier that made the original decision, Mr. Gaines said.

He recommended submitting all relevant evidence in support of the claim when the notice of reconsideration is submitted because this is a new review and the QIC will not consider what the carrier ruled previously.

QICs are bound by Medicare national coverage decisions, CMS rulings, laws, and federal regulations. But they are not bound by other documents including local coverage decisions, program guidance, or manual instructions, he said. The reconsideration decision is rendered within 60 days under the appeals process.

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► **Step 3.** A hearing with an administrative law judge is held in person, by video, or by telephone. Otherwise, the administrative law judge (ALJ) will base his or her decision on the written record. To have an ALJ review the appeal, submit a written request within 60 days of the reconsideration notice. At this level of the appeal, at least $110 must be in dispute.

In order to get an in-person hearing, physicians must make that request before the hearing date is set and explain why a telephone or video hearing is not acceptable, Mr. Gaines said. Consider obtaining legal counsel at this point in the process, Mr. Gaines advised.

► **Step 4.** If still not satisfied, a provider may appeal to the Medicare Appeals Council. This must be done within 60 days from the receipt of the ALJ decision. The Medicare Appeals Council is another addition to the process. Previously, physicians who wanted to appeal a decision beyond the ALJ would have to go to federal district court, and few physicians took that step, Mr. Gaines said.

There is no right to a hearing before the council but physicians can request an oral argument. In addition, parties to the appeal can file briefs.

► **Step 5.** The final appeal is to the federal district court. This must be filed within 60 days of the Medicare Appeals Council decision. The case may be filed in the U.S. District Court where the appealing physician resides. At this step in the process, at least $1,090 must still be in dispute. ■