

# *Claim Rejections and Appeals Process*



*Practical Tools for Seminar Learning*

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## Faculty

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**Dianne M. Willard, MBA, RHIA, CCS-P**

Dianne M. Willard has 24 years of progressive experience in Health Information Management. Ms. Willard is currently the Coding Integrity Program Administrator at Northwestern Memorial Hospital in Chicago, IL. Her career includes Consulting Management and Coding Consulting for various hospitals, clinics, physician groups, and academic medical centers. She was also employed at the American Health Information Management Association as the Director of Coding Services and at the American Medical Association in the Department of Coding. Dianne has presented on various coding and management topics at local, state, and national meetings and has written numerous articles on coding and compliance.

## Table of Contents

---

Disclaimer .....	i
How to earn one (1) CEU for participation .....	i
Faculty .....	ii
Objectives .....	1
Understanding Reasons for Rejected Claims	
Billing Issues.....	2
Coding Issues .....	2
Other Issues .....	3
Effective Claims Management.....	3-4
Medical Necessity Denials .....	4
Understanding Medicare's Appeal Process	
Appeals process changes .....	5
Appeal levels.....	5
Resource/Reference List .....	6
AHIMA Audio Seminars .....	6
About assessment quiz .....	7
Thank you for attending (with link for evaluation survey) .....	7
Appendix .....	8
Web Resource List.....	9
Attachments	
Denials Management--The Secret to Correct Coding .....	10
CMS Appeals Fact Sheet... New Medicare Claims Appeals Process .....	13
CMS General Appeals Process in Initial Determinations .....	18
Assessment Quiz	
CE Certificate and Sign-in Instructions	
Quiz Answer Key	

## Objectives



- **Understand what causes rejected claims**
  - Common billing issues
  - Common coding issues
  - Using the Medicare Coverage Database
    - National Coverage Determinations (NCDs)
    - Local Coverage Determinations (LCDs)

*Continued...*

1

## Objectives

*(Continued)*

- **Discuss effective claims management**
  - Base-line data tracking
  - Monitoring tools
- **Understand Medicare appeal process**
  - Appeal process changes
  - Level of appeals

2

## *Understanding Reasons for Rejected Claims*

### • **Billing Issues**

- Performing PIN is not valid
- Primary Insurer's Name not listed or illegible
- Service denied for insufficient information for referring/ordering physician
- Name or Medicare Number is incorrect
- Service not payable, claim is missing information/documentation zip code of service location
- CLIA number inaccurate or missing

3

## *Understanding Reasons for Rejected Claims*

### • **Coding Issues**

- Code and/or modifier incorrect/invalid
- Diagnosis is not coded to the highest level of specificity
- Diagnosis code reference number is missing

4

## Understanding Reasons for Rejected Claims

### • Other Issues

- Duplicate claim submission
- Claim not received timely
- Medical necessity denials



5

## Effective Claims Management

- Establish base-line data management program
  - Measure and track denial data
  - Analyze denials for patterns and trends
  - Review payer reimbursement policies to understand covered services
  - Appeal claims with legitimate reimbursable services
  - Analyze root causes of denials
  - Modify current processes to avoid future denials

*Continued...*

6

## ***Effective Claims Management***

- **Establish base-line data management program** *(continued)*
  - Educate physicians and staff on process/procedure changes
  - Meet with payers to discuss reimbursement issues
  - Follow-up and track all appeals
  - Re-work internal procedures and re-educate as needed

Source: "Denial Management – The Secret to Correct Coding,"  
AHIMA Convention, October 2005

7

## ***Medical Necessity Denials***

- **Are services "reasonable and necessary" to:**
  - Diagnose or treat an illness or injury
  - Improve functioning
  - Prevent illness
  - Manage terminal illness
- **Documentation to support medical necessity**

8



***Understanding Medicare's Appeal Process***

- **Appeals process changes**
  - **Benefit Improvement and Protection Act of 2000**
  - **Uniform Appeal process for Part A and Part B claims**
  - **Establishment of Qualified Independent Contractors**

9

***Understanding Medicare's Appeal Process***

- **Appeal levels**
  - **Redeterminations**
  - **Reconsiderations**
  - **Administrative Law Judge Hearing (ALJ)**
  - **Departmental Appeals Board Review (DAB)**
  - **Federal Court Review (Judicial)**

10

## Resource/Reference List

- “Denials Management – The Secret to Correct Coding,” AHIMA Body of Knowledge
- CMS Appeals Fact Sheet
- General Appeals Process, MLN Matters #MM4019
- “Unprocessable or Rejected Claims”  
[www.medicarenhic.com](http://www.medicarenhic.com)

*See appendix of seminar resource book*

11

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## Appendix

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Web Resource List

Attachments

Denials Management--The Secret to Correct Coding

CMS Appeals Fact Sheet: Implementing a New Medicare Claims Appeals Process

CMS General Appeals Process in Initial Determinations

Assessment Quiz

CE Certificate and Sign-in Instructions

Quiz Answer Key

## Appendix

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### Web Resource List

"Denials Management--The Secret to Correct Coding." AHIMA's 77th National Convention and Exhibit Proceedings, October 2005.

[http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok3\\_005643.hcsp](http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok3_005643.hcsp)

[Member login required; THIS ITEM IS ATTACHED]

CMS Appeals Fact Sheet: Implementing a New Medicare Claims Appeals Process, 3/1/05

[THIS ITEM IS ATTACHED]

CMS "General Appeals Process in Initial Determinations." MLN Matters #MM4019

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf>

[THIS ITEM IS ATTACHED]

"Unprocessable or Rejected Claims" NHIC, Inc.

[http://www.medicarenhic.com/ne\\_prov/articles/unprocessclaims\\_0606.htm](http://www.medicarenhic.com/ne_prov/articles/unprocessclaims_0606.htm)

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Room 303-D  
200 Independence Avenue, SW  
Washington, DC 20201



**Public Affairs Office**

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## **MEDICARE FACT SHEET**

FOR IMMEDIATE RELEASE  
March 1, 2005

Contact: CMS Press Office  
(202) 690-6145

### **IMPLEMENTING A NEW MEDICARE CLAIMS APPEALS PROCESS**

**Background:** In Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress required a major restructuring to improve the process that Medicare beneficiaries can use to appeal claims denials. The law includes a series of structural and procedural changes to the appeals process, including:

- Uniform appeal procedures for both Part A and Part B claims;
- Reduced decision-making time frames for most administrative appeals levels, as well as the right to escalate a case that is not decided on time to the next appeal level;
- The establishment of new entities, Qualified Independent Contractors (QICs), to conduct reconsiderations of claims denials made by fiscal intermediaries, carriers, and quality improvement organizations;
- Use of QIC review panels, which include medical professionals, to reconsider all cases involving medical necessity issues; and
- A requirement for appeals-specific data collection by CMS.

On December 8, 2003, following publication of the proposed rule, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) was enacted. The MMA includes a number of provisions that affect the Medicare claim appeals process. Most notably the new law includes:

- Revised redetermination and reconsideration decision-making time frames;
- A reduction in the minimum required number of QICs from 12 to 4;
- A requirement to transfer the ALJ function from SSA to HHS no earlier than July 1, 2005, but not later than October 1, 2005;

- Revised requirements for appeals decision notices;
- A requirement for providers and suppliers to present any evidence for an appeal no later than the QIC reconsideration level, unless there is good cause that prevented the timely introduction of the evidence; and
- The establishment of a process for the correction of minor errors or omissions without pursuing an appeal.

Several of these changes were already part of CMS' proposed rule. To the extent that the new statutory requirements have required revisions or additions to our proposed regulations to ensure that they conform to the MMA, we have incorporated the needed changes into the interim final rule, and discussed them in the appropriate section of the preamble.

Since the enactment of BIPA and MMA, CMS has been working aggressively to implement the substantial changes required by the law. For example, changes we have already implemented include:

- Development of a case-specific appeals data base;
- Award of contracts to the new required appeals entities—Qualified Independent Contractors (QICs); and
- Implementation of new improved notice requirements for current Medicare contractors.

Today, CMS published an interim final rule that will enable us to complete implementation of the new appeals process.

## **Implementation**

The statutory appeals provisions dramatically reduce the time frames for adjudicating fee-for-service Medicare claims appeals – a process that now can exceed 1,000 days must be reduced to 300 days. This change requires a substantial overhaul of the appeals process – a complicated restructuring involving all levels of the Medicare appeals process. CMS has worked aggressively to implement these mandatory changes, culminating in this regulation.

Today, CMS is publishing an interim final rule that establishes new regulations for implementing the new appeals process for claims denials required by section 521 of BIPA and the MMA. This final rule sets forth in one location all regulations covering administrative appeals of Medicare Part A and Part B claims, including for the first time Medicare-specific procedures for carrying out ALJ hearings. The interim final rule sets forth regulations to implement all structural and procedural changes to the existing appeals process. Implementation of these new procedures will take place in two stages. First, beginning on May 1, 2005, all first level appeals

(“redeterminations”) carried out by fiscal intermediaries (generally Part A appeals) will be subject to QIC reconsiderations. These appeals generally involve Medicare Part A services, such as services furnished by hospitals, skilled nursing facilities, and home health agencies. Then, beginning January 1, 2006, appeals of redeterminations carried out by Medicare carriers (Part B appeals, involving physician services and durable medical equipment items, for example) will be subject to QIC reconsiderations. The new ALJ rules will be in effect for all appeals that come through the QICs. Thus, in 2006, the new Medicare appeals process will take effect for all Part A and B Medicare claims.

###





## Denial Management--The Secret to Correct Coding

*Joette Derricks, MPA, CMPE, CPC, CHC, and Janis Cogley, RN, CPC, CHC, CCS-P*

### Introduction

For most healthcare providers, Medicare is the largest payer. According to the Centers for Medicare & Medicaid Services (CMS), it rejects 26 percent of the services it processes, with 40 percent of these never rebilled. This results in 11 percent of all Medicare claims never being adjudicated.<sup>1</sup> Industry experts find that most third-party payers, including managed care organizations, have similar rejection rates. Many estimate that one out of five claims is underpaid, resulting in 5 percent of net revenue being lost. Other studies indicate that the percentage of denials that may be prevented is as high as 90 percent and 67 percent are recoverable through the appeal process.<sup>2</sup> While revenue cycle enhancement and denial management teams are becoming an accepted standard for hospitals and physician practices today, thousands of dollars in rightful reimbursement is being sacrificed.

Many payers, including Medicare, cite the top two reasons for denials as duplicate claim submission and medical necessity denials. In 2002, Medicare denied over 21 percent of services submitted due to medical necessity reasons. Some of these services do not meet the required National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Other services are denied due to incorrect diagnosis coding, procedure code, or modifier usage. These services are often reimbursed once the error is detected and the service is appealed.

A well-tuned denial management program will result in the analysis, detection, and future avoidance of these unnecessary coding errors. This paper and our accompanying presentation on Denial Management—The Secret to Correct Coding provide a proven approach to implement a denial management program that ensures proper feedback and education are conducted so future claims are correctly coded.

### Methodology

#### The Denial Management Process

Denials happen for different reasons. Some denials are due to registration errors, such as changes in the patient's name or in their insurance coverage not being caught at the front-end. Some administrative errors, like forgetting to enter the name of a facility or transposing the numbers in diagnosis or procedure codes, are errors that even with the best procedures and training may happen from time to time. A denial management program should investigate all types of errors, including administrative errors, for patterns and trends.

The basic components required for a denial management program are the same regardless of the denial reasons—they are as follows:

- Track and measure denial data
- Analyze data for patterns and trends
- Review payer's reimbursement policies
- Appeal legitimate reimbursable services
- Identify root cause for the denial
- Change front-end or internal processes to avoid future denials
- Educate staff and physicians as necessary on changes
- Follow up on appeals
- Meet with payers to discuss reimbursement issues
- Continue tracking and monitoring process
- Rework internal procedures as necessary

Setting into place a denial management program with these components will uncover coding issues that result in lost revenue and that are preventable. As the denial management team drills down the data to identify the root cause and to improve their policies and procedures, they will learn how to code these services correctly and avoid future unnecessary denials.

## **Software Tools or Manual Processes**

Software vendors are responding to healthcare providers' needs to be able to quickly and easily capture and track denial reasons. CMS and various professional organizations capture national and provider specific data, regarding the top denial reasons, and the number of services and dollar amount denied. This information can help in benchmarking provider specific data to trends and patterns. In addition to back-end tracking and reporting software, most vendors now offer enhanced front-end edit packages to detect missing or incorrect data prior to the services being submitted to a payer. Of most interest are the enhanced solutions designed to detect medical necessity issues and identify when an Advanced Beneficiary Notice (ABN) is required.

Hospitals are embracing these new software programs. It is common to find enhanced front-end screening programs in hospitals' outpatient registration, scheduling, laboratory, radiology, and other departments. Physician practices and clinics are beginning to recognize the importance of these new software programs. The software can include a database of NCDs, LCDs, Correct Coding Initiatives (CCI) edits, and payer-specific requirements. By identifying mismatched procedure and diagnosis codes at the beginning of the revenue cycle, and verifying source documentation, the service can be billed to the payer with the confidence that it is correct when submitted. If the service does not meet the requirements, and it is furnished to a Medicare patient, the patient may be billed if it is a statutory non-covered service or if an ABN was obtained. This process saves valuable back-end resources by eliminating the need to rework the service.

For medical practices and clinics that are unable to, or unconvinced of the return on investment in software to track and measure denials, they may establish a manual logging process to still gain valuable data. One approach is to track a week or month of rejections by provider, location, payer, procedure, diagnosis, and denial reason. So that the process is not overwhelming, they many want to track data for only one payer or one location at a time. The process can be repeated two or three other times during the year to ascertain trends and patterns. At a minimum the practice should be able to identify the top 10 reasons why their claims are being denied and the number of denials and dollar value of denials for each reason.

## **Attacking Medical Necessity Denials**

Title XVIII of the Social Security Act requires that Medicare services be “reasonable and necessary.” Services are considered to meet medical necessity guidelines if they are performed for one of the following reasons:

- To diagnose or treat a patient’s illness or injury
- To improve the functioning of a malformed body member
- To prevent an illness
- For the palliation and management of terminal illness

In addition, the service must be safe and effective, may not be experimental or investigational (although there are some exceptions), and must be appropriate based on the duration and frequency of the service; the setting the service is furnished in must be appropriate and the service must be ordered and/or furnished by qualified personnel, and meet but not exceed the patient’s medical needs. Finally, the service must be at least as beneficial as an existing and available medically appropriate alternative.

Medicare’s NCDs and fiscal intermediaries/carriers LCDs provide guidance as to what is or is not medically necessary. An LCD may be developed if there is no national coverage guideline. Many other payers follow the standards set by the Medicare program; however, there is no requirement for them to do so. To properly submit services to other payers, the practice or clinic must devote time to learn how its major payers will adjudicate their claims.

Once the denial management team has identified the top procedure and diagnosis codes that are being denied, the corresponding payer guidelines are investigated. If the diagnosis is not a qualified reason to provide the service, the source document must be checked to see if a different or better diagnosis was available but not coded. The next step is drilling down to determine why the correct diagnosis that is supported by the medical record was not coded. Key questions to ask include:

- Was the incorrect code circled on the encounter form?
- Is the encounter form outdated?
- Is there adequate space to write in the correct diagnosis code?
- Was it coded correctly but transposed in data entry?
- Does the billing software bring up the most recent diagnosis and the entry clerk failed to change it to the current diagnosis?

Another range of possibilities is to explore whether the physician did not elaborate sufficiently on what was done at the time of service and why it was done. These are all important questions to find out what the root cause is for the denial. Of course, it is important to always emphasize that it is considered fraudulent to re-bill the service with a payable diagnosis code that is unsupported by the medical records.

Once the root cause is determined, corrective action should be initiated. This may require updating forms, establishing new or modifying current procedures, or providing staff and physicians with more training.

## **The Appeals Process**

While tracking denials and investigating the root causes for them will avoid future rejections, the current ones cannot be ignored. They must be worked within the payer's timeline requirements for an appeal. Each payer has their own appeal mechanism and understanding the specific requirements for that payer is a must. The success of a clinical appeal is often contingent on new or additional documentation that was not provided with the original claim. The process to work denials is labor intensive; thus, the emphasis on avoidance.

Most payers have at least three levels of appeals. The specific timeframes to take advantage of each level may vary. A level-one appeal is reconsideration by the payer staff that adjudicated the original claim. It generally involves the submission of new or additional information for their consideration. A level-two appeal is generally a review by a physician or medical director and focuses primarily on the medical necessity of the service provided. A level-three review is more formal and may require attendance at a medical review appeals committee or board meeting. In most cases, following the third appeal level any subsequent appeal requires litigation.

The Social Security Act establishes the right of participating providers as well as beneficiaries to appeal the initial determinations of claims made by CMS. Similar to the system in place by other payers, the Medicare appeal process consists of three levels. Previously known as claim review, fair hearing, and administrative law judge (or peer review on the Part A side), the Benefits Improvement and Protection Act of 2000 (BIPA) mandated that CMS make changes to their appeals process.

However, prior to BIPA being fully implemented, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required additional changes in the appeal process. On March 1, 2005, CMS released an interim final rule that establishes new regulations for implementing the new appeals process for claims denials required by section 521 of BIPA and the MMA.<sup>3</sup> The statutory appeals provision dramatically reduces the amount of time involved in moving through all three levels of the Medicare appeals process. Previously, decisions may be pending at one of the levels for several years, and delays up to three years to move a claim through the entire process were not unusual. These changes mandate a complete and substantive overhaul of the entire Medicare appeals process and require that claims be adjudicated through all three levels within 300 days.

The implementation of the structural and procedural changes to the existing appeal process will take place in two stages. The first began on May 1, 2005, and requires that all first level appeals carried out by fiscal intermediaries (generally Part A appeals) will be subject to Qualified Independent Contractors (QICs). The second stage, beginning on January 1, 2006, requires that all Part B first level appeals also be subject to QIC reconsiderations. The new administrative law judge rules will also be in effect as of January 1, 2006, for all appeals that go through the QIC process and are moving on to a higher level appeal. Thus, in 2006 the new Medicare appeals process will be in effect for all Part A and B Medicare claims. Additional details as to the specific requirements will be released in the near future by CMS.

## **Conclusion**

There is extensive case documentation of hospitals and clinics that have successfully cut their claims denial rate by 50 percent or more or have recouped millions in revenue. While implementation of an effective denial management system may achieve similar success in

your facility or practice, the secret to obtaining such sizable cuts is to uncover the root cause for the denial. While this often is a labor intensive process, especially as applied to medical necessity rejections, the real savings only become possible through future avoidance of the denial.

## Endnotes

1. Centers for Medicare & Medicaid Services, Baltimore, MD. December 2000 Report.
2. The Advisory Board Company, "CFO Leadership Strategies for Managing Denied Claims," 2004.
3. *Federal Register* 70, no. 44, March 8, 2005, "Rules and Regulations."

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**Source:**

Derricks, Joette, Cogley, Janis. "Denial Management--The Secret to Correct Coding." AHIMA's 77th National Convention and Exhibit Proceedings, October 2005.

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Related Change Request (CR) #: 4019

MLN Matters Number: MM4019

Related CR Release Date: October 7, 2005

Related CR Transmittal #: 695

Effective Date: May 1, 2005

Implementation Date: January 9, 2006

## *MMA – Changes to Chapter 29 – General Appeals Process in Initial Determinations*

**Note:** This article was revised to contain Web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

### Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare

### Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

CR4019 focuses on the general appeals process in Initial Determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual*.

### Key Points

#### *Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process*

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

#### *Minor Errors and Omissions*

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

*Who May Appeal*

CR4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor’s initial determination. (Medicare contractors are carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a “party.”

**Provider or Supplier Appeals When the Beneficiary Is Deceased**

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor’s responsibility to determine whether another party is available to appeal. CR4019 describes what must be done in this situation.

*Parties to an Appeal*

Any of the persons/entities who may appeal Medicare’s decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

*Steps in the Appeals Process: Overview*

The process of appeal described in CR4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

**The Medicare Fee-for-Service Appeals Process**

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
<b>1. Redetermination</b>			
<ul style="list-style-type: none"> <li>Performed by the Medicare Contractor</li> </ul>	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	<b>Part A – FI (MAC)</b> <b>Part B – Carrier (MAC)</b>	None
<b>2. Reconsideration</b>			
<ul style="list-style-type: none"> <li>Performed by QIC</li> <li>Case file prepared by the Medicare contractor and forwarded to the QIC.**</li> <li>Medicare contractor may have effectuation responsibilities for decisions made by the QIC.</li> </ul>	180 days from date of receipt of the redetermination	<b>Part A and B – QIC</b>	None
<b>3. Administrative Law Judge (ALJ) Hearing</b>			
<ul style="list-style-type: none"> <li>Case file prepared by the QIC</li> </ul>	60 days from the date of receipt of the	<b>Part A and B</b>	At least \$100 remains in

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Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). <ul style="list-style-type: none"> <li>Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.</li> </ul>	reconsideration notice	- HHS OMHA Field Office	controversy*** <i>For requests made on or after January 1, 2006, at least \$110 remains in controversy</i>
<b>4. Departmental Appeals Board (DAB) Review</b>			
<ul style="list-style-type: none"> <li>Contractor may have effectuation responsibilities for decisions made at the DAB level.</li> </ul>	60 days from the date of receipt of the ALJ hearing decision/dismissal	<b>Part A and B</b> - DAB	None
<b>5. Federal Court (Judicial) Review</b>			
<ul style="list-style-type: none"> <li>Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.</li> </ul>	60 days from date of receipt of DAB decision or declination of review by DAB		At least \$1,050 remains in controversy*** <i>For requests made on or after January 1, 2006, at least \$1,090 remains in controversy</i>

\*Where to Appeal - Part A includes Part B claims filed with the FI.

\*\* In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

\*\*\*Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar Amount in Controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

**Where to Appeal**

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

**When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals**

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

**Good Cause - General Procedure to Establish Good Cause for Late Filing**

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an

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unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries or by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

### *Amount in Controversy (AIC) Requirements*

The amount in controversy requirements apply only to the ALJ and Federal Court Levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

### **Additional Information**

The official instruction issued to your FI or carrier regarding this change may be found by going to <http://www.cms.hhs.gov/transmittals/downloads/R695CP.pdf> on the CMS web site.

All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number, go to <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

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## Assessment Quiz – Claim Rejections and Appeals Process

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To earn continuing education credit of one (1) AHIMA CEU, Fast Facts Audio Seminar listeners must also complete this 10-question quiz. This CE credit is for attending the audio seminar AND completing this quiz. Please **keep a copy** of the completed quiz with your CE certificate. **Do not send a copy to AHIMA.**

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1. A common billing rejection for physician office claim is:
    - a. ICD-9-CM procedure codes listed
    - b. Name or Medicare Number is missing
    - c. ABN is invalid
    - d. Claim is not electronic
  2. Coding rejections include:
    - a. Lack of specificity in diagnosis code
    - b. Missing diagnosis reference number
    - c. Modifier not valid due to CCI edits
    - d. All of the above
  3. True or false? One of the major causes of rejected claims is duplicate claims submission.  
True  
False
  4. The first appeal level for medical claims is \_\_\_\_\_.
    - a. Reconsideration
    - b. Redetermination
    - c. Departmental Appeal Board
    - d. Administrative Law Judge Hearing
  5. True or false? The appeal process is the same for Medicare Part A and Part B.  
True  
False
  6. Medical Necessity refers to services and procedures that are \_\_\_\_\_.
    - a. Usual and customary
    - b. Preventative
    - c. Required by law
    - d. Reasonable and necessary
  7. The appeals process change was part of the \_\_\_\_\_.
    - a. Benefit Improvement and Protection Act of 2000
    - b. Appeal Process Act of 2000
    - c. Medicare Carrier Revision Act
    - d. NCCI Edits
  8. True or false? Appeals are never a judicial review.  
True  
False
  9. Effective claims management includes:
    - a. Analyzing denials for patterns and trends
    - b. Analyzing root causes of denials
    - c. Reviewing payer reimbursement policies
    - d. All of the above
  10. The \_\_\_\_\_ contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
    - a. Global Determination Database
    - b. Medicare Coverage Database
    - c. Medicare Review Policy
    - d. National Carrier Databank
- 

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## **Quiz Answer Key**

### **Fast Facts Audio Seminar: *Claim Rejections and Appeals Process***

1: b; 2: d; 3: true; 4: b; 5: true; 6: d; 7: a; 8: false; 9: d; 10: b

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