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Cardiology Coding Alert

Appeals: Navigate the Medicare Part A and B Appeals Process With Ease

Dig into the 5 levels of the appeals process.

You submit a claim to your MAC for a Part B patient, but Medicare denies the claim. You want to appeal the decision, but you have no idea how to move forward.

The MAC National Government Services recently held a webinar to help clarify the five levels in the Medicare Part A and Part B appeals process. Read on to make sure you understand how the process works so you don't lose any well-deserved reimbursement in your cardiology practice.

See How Reopenings Differ From Appeals

A reopening, also referred to as a preredetermination is not an appeal, but a request to reopen a claim, according to **Shelly Dailey, MSN, BSN, RN, CPHM**, Medicare home health and hospice clinical consultant at National Government Services.

Reopenings are not processed through the appeals department and only occur at the discretion of the contractor, Dailey explains. If a contractor refuses to reopen a claim for a minor error, that decision is not appealable.

Timeline: A reopening can be performed within one year of the claim's finalized date, Dailey says.

There are several reasons for a reopening, according to Dailey. These include the following:

- Mathematical errors
- Transposed procedure diagnostic codes
- Inaccurate data entry
- Computer errors
- Incorrect data items such as the provider number or »the date of service.

On the other hand, appeals are different from reopenings. You cannot file an appeal for a reopening.

Appeals: Before an appeal request can be made, you first have a processed claim, according to Dailey. When Medicare has either fully or partially denied the claim, then you may submit an initial appeal for a redetermination, which is also known as a Level 1 appeal.

The purpose of the appeals process is to "ensure correct adjudication of claims," Daily explains. CMS governs all appeals activities. Additionally, all providers and beneficiaries have the right to appeal any claim determination their MAC makes.

Observe Levels of Appeals Process

There are five levels of the appeals process. They are as follows:

- **Level 1:** Redetermination, which goes through your MAC. **Caution:** For a redetermination Level 1 appeal to be considered complete, the provider must include all of the following information: the beneficiary's name; the Medicare number; the requested service; the date of service; and the name and signature of the requesting individual. If all of these elements are not included with your initial Level 1 appeal, your MAC will dismiss the case as incomplete, according to Dailey.
- **Level 2:** Reconsideration, which goes through the qualified independent contractor (QIC). Requests for

Level 2 appeals can only be made in writing.

- **Level 3:** Administrative Law Judge Hearing (ALJ). Requests for Level 3 appeals can be made in writing only. Also, your claim must be worth at least $160 to file a Level 3 appeal.
- **Level 4:** Medicare Appeals Council Department Appeals Board (DAB). Claims for a Level 4 appeal must also be worth at least $160.
- **Level 5:** US Federal District Court. Claims for a Level 5 appeal must be worth at least $1,630.

Don't miss: Documentation is the key to the success of any level of appeal, Dailey says. Providers must include all pertinent information to avoid the dismissal of the case.

Pay Attention to Time Limits

There are strict time limits for filing at each level of appeal, Dailey explains. They are as follows:

- For the Redetermination, you have 120 days from »the date of receipt of your denial to file another appeal. The MAC then has 60 days to review your redetermination.
- For the QIC Reconsideration, you have 180 days »from the receipt of your redetermination notice to file another appeal. QIC has 60 days to complete the review.
- For the ALJ Hearing, you have 60 days from the »receipt of your reconsideration notice to file another appeal. The ALJ has three months to complete the review.
- For the DAB Review, you have 60 days from the »receipt of the ALJ decision to file another appeal. The DAB has 90 days to review the claim.
- For the Judicial Review, you have 60 days from »the receipt of the DAB decision to file another appeal. The Judicial Review has 60 days to complete their review.