Medicare Part B 2024

Spring/Summer Virtual Conference

Mastering Medicare: Tuesday Tutorials

Introduction to Appeals

6/11/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

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Objective

To educate providers on the Medicare appeal process basics and to review top reasons providers have to appeal claims. We'll also provide helpful information to prevent having to appeal your claim.

Today's Presenters

- Provider Outreach and Education Consultants
  - Gail Toussaint
  - Lori Langevin

Agenda

- Five Levels of Appeal
- Redetermination
- Reopening
- Unprocessable Claims
- Appeal Submission Reminders
- Top Reasons for Appeals
- Helpful Tips to Avoid Appeals
- Resources

Five Levels of Appeal

Level One

- **Redetermination**
  - Time limit for filing
    - 120 days from date of receipt of the initial claim determination notice
  - Amount in controversy requirement
    - No minimum
  - Remittance advice code MA01
    - Indicates there are appeal rights associated with the service

Level Two

- **Reconsideration (QIC)**
  - Time limit for filing
    - 180 days from date of receipt of the redetermination decision
  - Amount in controversy requirement
    - No minimum

Level Three

- **Administrative Law Judge Hearing**
  - Time limit for filing
    - 60 days from date of receipt of the reconsideration (QIC) decision
  - Amount in controversy requirement
    - $180 minimum

Level Four

- **Medicare Appeals Council**
  - Time limit for filing
    - 60 days from date of receipt of the ALJ decision
  - Amount in controversy requirement
    - No minimum

Level Five

- **Federal Court Review**
  - Time limit for filing
    - 60 days from date of receipt of the appeals council decision
  - Amount in controversy requirement
    - $1,840 minimum

Levels of Appeals and the Appeals Process

Contact Us | NGSConnex | Subscribe for Email Updates | Part B Provider in Maine (JK)

HOME | EDUCATION | RESOURCES | EVENTS | ENROLLMENT | APPS

Resources › Claims and Appeals

ABOUT APPEALS

- Tip Sheet for Medicare Providers on First Level of Appeals (Redeterminations)
- About Appeals
- Reopening versus Redetermination
- Who May File an Appeal?
- **Levels of Appeals and Time Limits for Filing**
- MSP Overpayments
- Initiate Part B Reopenings or Non-MSP Overpayment Adjustments in NGSConnex
- What Documents are Needed
- Submit an Appeal Electronically with NGSConnex
- Submit an Appeal Electronically via esMD
- Get Help Submitting a Appeal Hard Copy
- How to Prevent Duplicate Appeal and Clerical Error Reopening

Levels of Appeals and Time Limits for Filing

Table of Contents

- Five Levels of Appeals: Overview
  - Level One – Redetermination
  - Level Two – Reconsideration (QIC)
  - Level Three – Administrative Law Judge (ALJ)
  - Level Four – Medicare Appeals Council (MAC)
  - Level Five – Federal Court Review

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Five Levels of Appeals: Overview

Level One – Redetermination

- Time Limit for Filing a Redetermination - 120 days from date of receipt of the initial determination notice
- Amount in Controversy - No minimum (none)

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Level Two – Reconsideration (QIC)

- Time Limit for Filing a Reconsideration - 180 days from date of receipt of the redetermination decision

Helpful Resources

- Log Into NGSConnex
- Appeals Timeline Calculator
- YouTube Video: Holistic Approach to Avoiding Administrative Burden

Form(s) you'll need:

- Appeal Forms

Redetermination

What Is a Redetermination

- A redetermination is an examination of a claim by Part B National Government Services appeals level personnel
- Request in writing or online via NGSConnex
- Attach supporting medical documentation
  - i.e., anesthesia reports, operative reports, progress notes, documentation of medical necessity, test results, etc.

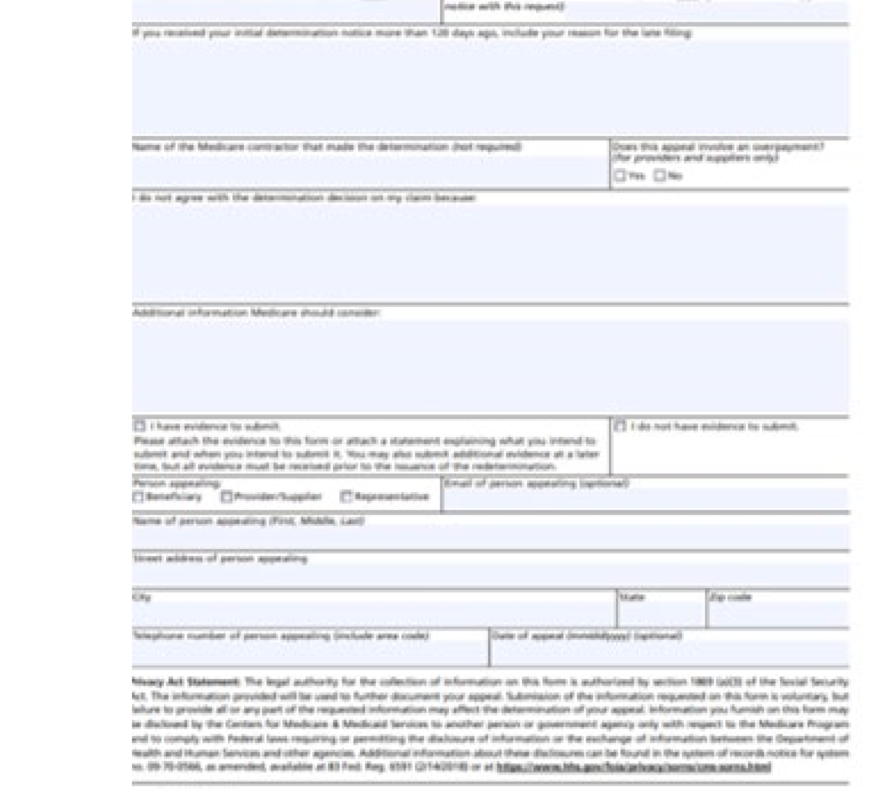
Redetermination Request Form

- CMS-20027 Redetermination Request Form
- CMS Forms List
- **JK**

  National Government Services
  P.O. Box 7111
  Indianapolis, IN 46207-7111

- **J6**

  National Government Services
  P.O. Box 6475
  Indianapolis, IN 46206-6475



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

MEDICARE REDETERMINATION REQUEST FORM — 1st LEVEL OF APPEAL

Beneficiary's name (First, Middle, Last)

Medicare number | Item or service you wish to appeal

Date the service or item was received (mm/dd/yyyy) | Date of the initial determination notice (mm/dd/yyyy) (please include a copy of the notice with this request)

If you received your initial determination notice more than 120 days ago, include your reason for the late filing

Name of the Medicare contractor that made the determination (not required) | Does this appeal involve an overpayment? (for providers and suppliers only) ☐ Yes ☐ No

I do not agree with the determination decision on my claim because:

Additional information Medicare should consider:

☐ I have evidence to submit.
Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

☐ I do not have evidence to submit.

Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative | Email of person appealing (optional)

Name of person appealing (First, Middle, Last)

Street address of person appealing

City | State | Zip code

Telephone number of person appealing (include area code) | Date of appeal (mm/dd/yyyy) (optional)

Privacy Act Statement:

NGSMU

Redetermination Request Form

- NGS Redetermination Request Form
- [Our Website]

- **JK**

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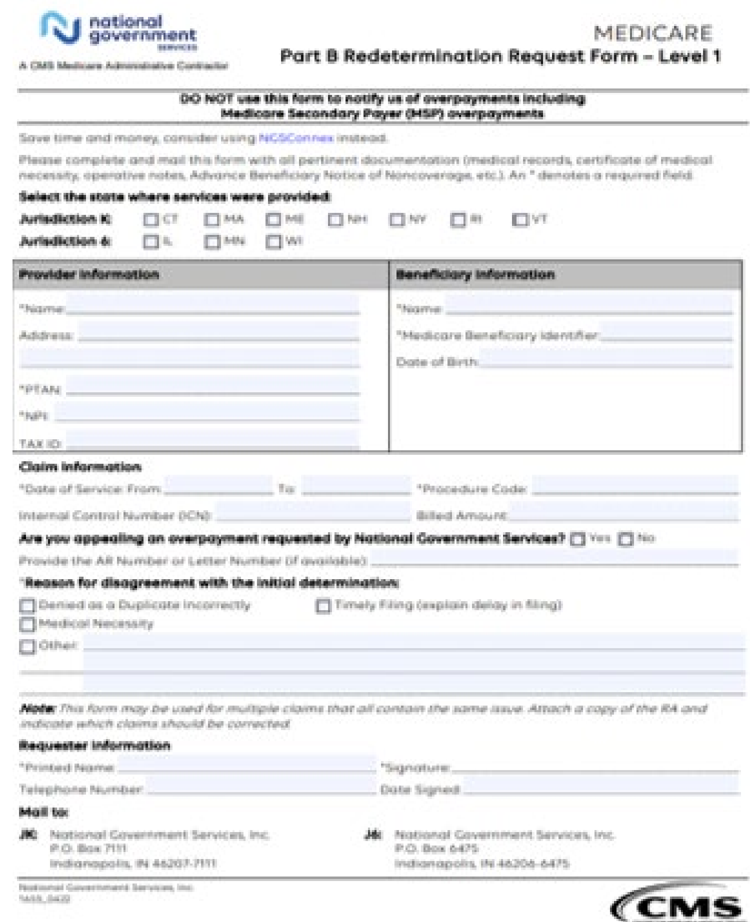

national government services
A CMS Medicare Administrative Contractor

MEDICARE
Part B Redetermination Request Form – Level 1

DO NOT use this form to notify us of overpayments including Medicare Secondary Payer (MSP) overpayments

Save time and money, consider using NGSConnex instead.

Please complete and mail this form with all pertinent documentation (medical records, certificate of medical necessity, operative notes, Advance Beneficiary Notice of Noncoverage, etc.). An * denotes a required field.

Select the state where services were provided:

Jurisdiction K: ☐ CT ☐ MA ☐ ME ☐ NH ☐ NY ☐ RI ☐ VT
Jurisdiction 6: ☐ IL ☐ MN ☐ WI

Provider Information	Beneficiary Information
*Name:	*Name:
Address:	*Medicare Beneficiary Identifier:
	Date of Birth:
*PTAN:	
*NPI:	
TAX ID:	

Claim Information

*Date of Service: From: ______ To: ______ *Procedure Code: ______
Internal Control Number (ICN): ______ Billed Amount: ______

Are you appealing an overpayment requested by National Government Services? ☐ Yes ☐ No
Provide the AR Number or Letter Number (if available): ______

***Reason for disagreement with the initial determination:**

☐ Denied as a Duplicate Incorrectly
☐ Timely Filing (explain delay in filing)
☐ Medical Necessity
☐ Other: ______

Note: *This form may be used for multiple claims that all contain the same issue. Attach a copy of the RA and indicate which claims should be corrected.*

Requester Information

*Printed Name: ______ *Signature: ______
Telephone Number: ______ Date Signed: ______

Mail to:

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Indianapolis, IN 46207-7111

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Indianapolis, IN 46206-6475

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Forms on Our Website

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Resources

FORMS

- All
- **Appeals**
- Coverage
- Customer Care
- Documentation
- Electronic Data Interchange
- Enrollment
- Other
- Overpayments

Appeals

- Appointment of Representative Form (CMS-1696)
- Level 1: Redetermination Request Form
- Level 2: Reconsideration Request Form (CMS-20033)
- Level 3: Request for an Administrative Law Judge Hearing or Review of Dismissal (OMHA-100)
- Level 4: Review of Hearing Decision Form (DAB-101)
- LVAM Request Form
- Reopening Request Form
- Transfer of Appeal Rights

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Appeals Calculator

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Resources › Tools & Calculators

APPEALS CALCULATOR

Appeals Calculator

To determine the timely filing date for your appeals request:

Step One

Please select an option from the drop-down based upon which level of appeal you are in (see table at bottom of page).

Step Two

Enter the date on which you received the response to your previous appeal.

Reminder: The filing time limit for each level of an appeal is calculated from the date you received a response to your previous filing.

Step One * Please - Select One

Step Two * mm/dd/yyyy

Calculate Reset

Five Levels of Appeals: Overview

Helpful Tips

- The beneficiary name, MBI number, date(s) of service and item/service at issue are required for any appeal to be processed
- Ensure all items are completed
- If there is not enough room on the form, please include an attachment that details the required information
- If there is insufficient information with your appeal request, it may be dismissed
- If you are submitting your appeal past the time limit, please include an explanation for the delayed request
- Include all medical record documentation that supports your request
- The medical record documentation must be signed and dated by the physician

Redetermination Timeframe

- National Government Services shall issue decision on appeals within 60 days
- If you have not heard, please do not resubmit another request
- Submit one redetermination request for all lines in question on a claim
- If you're a current NGSConnex user, you can check the status of your appeal at NGSConnex
- Please do not submit the appeal via paper and NGSConnex

Paperless Redetermination Process

- NGSConnex
  - Free, secure, web-based application
  - Initiate a redetermination for claims
- Learn about NGSConnex
  - NGSConnex webpage
- Learn about navigating the NGSConnex portal
  - NGSConnex User Guide
- NGS YouTube, "Navigating NGSConnex"

Redetermination Examples

- Disputing a recoupment
- Adding specific modifiers
  - See "Reopening Versus Redetermination" on our website
- Analysis of documents
  - operative reports, progress notes, consultation notes and/or radiology reports
- Cosmetic surgery
- LCDs and NCDs

Redetermination Examples – Cont.

- Limitation of liability issues
  - frequency, diagnosis and/or medical necessity
- Medical necessity denials for ambulance transports
- Procedures not deemed to be proven effective
- Requests for additional allowance
  - Modifier 22
- Screening procedures
- Services that deny as routine

Dismissed Redetermination

- To avoid a dismissed redetermination, ensure that you have complete requests with
  - Beneficiary's name
  - Beneficiary's Medicare number
  - Specific service(s)in dispute
  - Specific date(s) of service

Next Steps After Dismissal Letter

- Review missing content
- File your request again with complete information
  - If it has been 120 days or less since the date of receipt of initial determination notice
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29, Section 220
- Regulations at 42 CFR 405.940–405.942

Reopening

What Is a Reopening

- When a provider requests to reopen a claim(s) to correct minor, uncomplicated, clerical errors or omissions
  - Mathematical or computational mistake
  - Transposed procedure or diagnostic codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items
- Cannot add items or services that were not previously billed

Reopening versus Redetermination

- A reopening is a reprocessing of a claim to fix minor mistakes

- A redetermination is an examination of a claim that includes analysis of documentation

Request a Reopening

- NGSConnex
- You can submit a written request by completing and mailing the Part B Reopening Request Form
- Contacting the TRU (Telephone Reopening Unit)

Reopening Request Timeframes

- A party may request a contractor reopen and revise its initial determination or redetermination under the following conditions
  - Within one year from the date of the initial determination or redetermination for any reason; or
  - Within four years from the date of the initial determination or redetermination for good cause as defined in Section 10.11; or,
  - At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error as defined in Section 10.4
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 34, Section 10.6.2

Unprocessable Claims

What Is an Unprocessable Claim

- "Any claim with incomplete or missing, required information or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally."

Unprocessable Claims

- Rejected claim or MA130 denial
  - Claim contains incomplete/invalid information
  - No appeal rights – claim unprocessable
  - No reopening rights
- Fix error(s) and resubmit
  - Resubmit as a new claim
  - Do not indicate corrected claim
- Do not appeal

Unprocessable Claim Examples

- Missing, incomplete or invalid
  - Charges
  - CPT or HCPCS codes
  - Date of service
  - Diagnosis code(s)
  - ID: MBI
  - Line Item 11 – "none"
  - Line Item 17 and 17b – referring/ordering/supervising provider name and NPI
  - Line Item 19 – unlisted or NOC code(s) description

Unprocessable Claim Examples - Cont.

- Missing, incomplete or invalid
  - Name and date of birth
  - Place of service
  - Provider’s signature
  - Rendering or billing provider name and NPI

Appeal Submission Reminders

Appeal Submission Reminders

- Make sure you use the correct form
  - Part B Appeals Request Form: Redetermination: First Level of Appeal
- If your request is regarding general information, please send a letter with your specific question
- Not all claim determinations can be appealed or corrected
  - If your claim has the MA130 group reason code on the provider remittance, the claim must be resubmitted with the complete/correct information
- Reference PTAN number; not NPI number on redetermination form
- Include ICN for Part B claim in question on redetermination form

Appeal Submission Reminders (cont.)

- Submit one redetermination request for all lines in question on the claim; do not submit a redetermination form for each individual line of the claim
- Submit one redetermination form per claim; do not submit one redetermination form for multiple claims
- If using NGSConnex to submit a request, do not also mail your request
  - Also for submission via NGSConnex; do not submit the same appeal multiple times

Top Reasons for Appeals

Top Reasons for Appeals

- Duplicate denials
- Medical necessity denials
- CCI denials
- MUE denials

Duplicate Denials

- We are seeing these with reopenings
- Be sure to use the appropriate modifier
  - 76, 77, 78, 91, 59, 50, LT, RT
- Provide the appropriate medical documentation to prove all the duplicate services were performed
- Providers will receive a OA-18 on their remit

Medical Necessity Denials

- Majority of these claims are reviewed by a NGS clinician
- Be sure your original claim submission is following the LCD to alleviate a denial
- Providers will receive a CO-50 on their remit

Medical Necessity Denials
Local Coverage Determination

- LCD
  - A decision by Medicare contractor whether to cover a particular item or service
  - Contains information to indicate medically reasonable and necessary documentation
  - Should be used as an administrative and educational tool to assist providers in submitting correct claims for payment

Medical Necessity Denials
National Coverage Determination

- NCD
  - The CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual* describes whether specific medical items, services, treatment procedures, or technologies can be paid by Medicare

Medical Necessity Denials
LCDs and NCDs

- It is important to become familiar with LCDs and NCDs
  - **Note:** Not all covered Medicare services are subject to either an LCD or NCD
  - LCDs are linked to the MCD from the Medical Policy Center on our website
    - Medical Policy Center - LCDs
  - NCDs are located on the CMS website
    - Medicare Coverage Determination Process

Medical Necessity Denials
RARC N102

- Noncovered services because not deemed a 'medical necessity' by payer
  - Check the medical policy section of the website to ensure the service is considered medically necessary
  - Search by keyword, procedure name or procedure/HCPCS code
  - Review LCDs and articles

Correct Coding Initiative Denials

- Majority of these claims are reopenings
- Be sure to understand the NCCI process
- Providers will see CO-16 with reason code 236 on their remit

National Correct Coding Initiative

- Why was NCCI implemented?
  - Promote national correct coding methodologies
  - Control improper coding
- How to use NCCI
  - Report most comprehensive code
  - Use modifiers to report special circumstances
  - Refer to NCCI edit table
    - National Correct Coding Initiative Edits

Medically Unlikely Edits Denials

- NGS appeal’s nurse receives claim as redetermination
- Be sure to understand the MUE process
- Providers will receive a CO-16 with reason code-151 on their remit

Medically Unlikely Edits

- MUEs were developed to reduce the paid claims error rate for Part B claims
- An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service
- All HCPCS/CPT codes do not have an MUE
  - CMS Medically Unlikely Edits web page

Helpful Tips to Avoid Appeals

Verify Data

- Verify all data pertaining to the service is correct
  - NPI of billing physician/rendering physician
  - Assignment or nonassignment of claim
  - Beneficiary's Medicare number
  - ZIP code of the place of service
  - All related diagnoses reported with the highest degree of specificity
  - NPI of referring physician
  - Date of service/place of service

Review for Completeness

- Procedure code
- Modifiers when applicable
- Number of service(s) and billed amount for each service
- CLIA number for laboratory services
- The last visit date, X-ray date, initial treatment date for podiatry, physical therapy and chiropractic services
- Primary payer data

Modifiers

- Attach modifiers to services when applicable
  - Failure to append a modifier when appropriate will result in a denial
  - Modifiers provide the means to indicate a service or procedure performed has been altered by some specific circumstance but not changed in its definition or code
  - A list of modifiers and definitions is located on our website
    - Modifiers Used in CMS-1500 Claim Reporting

Modifier Usage

- Appropriate modifier scenarios include
  - Service or procedure has both a professional (26) and technical component (TC)
  - Duplicate service or procedure was performed by more than one physician (77)
  - Only part of a service was performed (54 or 55)
  - Bilateral procedure was performed (50)

Duplicate Service

- Modifier 76 – duplicate service or procedure was provided by the same physician
  - Document a repeat or duplicate service to reflect it is a distinct and separate service
    - Failure to document a repeat or duplicate service will result in a denial
  - Report clarifying information pertaining to repeat or duplicate services using Item 19 of the CMS-1500 claim form (02/12) or in the Extra Narrative Data segment (Loop 2300/2400) of the ANSI ASC X12 837 Versions of an electronic claim
    - Utilize this field to report the time of each subsequent or repeat service or the number of times this service needed to be performed

Distinct Services

- Report body site modifiers to indicate more than one of the same service is performed but on different body parts/sites, e.g., LT, RT, TA, T9
- Report modifier 59 to indicate a distinct procedural service
  - This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)

Increased Service

- Modifier 22 – service or procedure has been increased
  - Represents increased procedural services
  - The work required to provide a service is substantially greater than typically required
  - Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)

Reduced Service

- Modifier 52 – service or procedure has been reduced
  - Represents reduced services and when under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion
  - Explanation can be submitted by entering the information in Item 19 (CMS-1500 form) or in the Extra Narrative Data segment (Loop 2300/2400 of an electronic claim) or submitting the supporting documentation
  - [Modifier 52 Claim Submission Billing Reminder]

NOC Code

- Enter description of an unlisted procedure code (NOC code) or a “not otherwise classified” code
  - Failure to describe the NOC will result in a denial
  - Must be entered into Item 19 of the CMS-1500 claim form or in the Extra Narrative Data segment (Loop 2300/2400) of an electronic claim
- Please see the link below for NOC code instructions
  - Instructions for use of Not Otherwise Classified or Unlisted Codes

Extra Narrative Data

- Item 19 Extra Narrative Data segment is also used to describe other billing scenarios as follows
  - Enter the drug's name and dosage
  - Enter all applicable modifiers when modifier 99 (multiple modifiers) is entered
  - Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved
  - When dental examinations are billed, enter the specific surgery for which the exam is being performed
  - Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them
  - Enter the date for a global surgery claim when providers share postoperative care

MSP

- When Medicare is the secondary payer (MSP), the claim must include information from the primary insurer
  - Failure to include this information will result in a denial
  - To submit MSP claims using the CMS-1500 claim form (02/12), refer to CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3
  - To submit MSP claims electronically, refer to Medicare Secondary Payer Manual for Electronic Submitters/ANSI Specifications for 837P
  - Obtaining primary insurance information from the beneficiary is the provider's responsibility
    - Claim filing extensions will not be granted because of incorrect insurance information

Documentation

- Comply with requests for supporting documentation
  - Failure to comply with the request will result in a denial
  - NGS may solicit for more information by issuing an ADR
  - We will specify in the ADR the documentation needed to make the coverage or coding determination
  - Responses to ADRs should be received within the 45-day timeframe
  - We will complete the review within 60 days of receiving all requested documentation and notify the provider of the claim determination
  - Record or documentation requests where no timely response was received will result in denial indicating denial was made without reviewing the medical record

Signatures

- Supporting documentation must include an acceptable signature
  - Must include rendering physician's signature
  - Failure to provide valid signature will result in denial
  - Medicare contractors require a legible identifier for services provided or ordered
  - Only acceptable method of documenting provider signature is by written or electronic signature or, attestation or signature log
  - Stamped signatures are not acceptable
    - CMS will permit the use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability

Resources

Resources

- Our Website
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 34, "Reopening and Revision of Claim Determinations and Decisions"
- MLN Booklet® *Medicare Parts A & B Appeals Process (ICN 006562)*

Appeals Contact Information

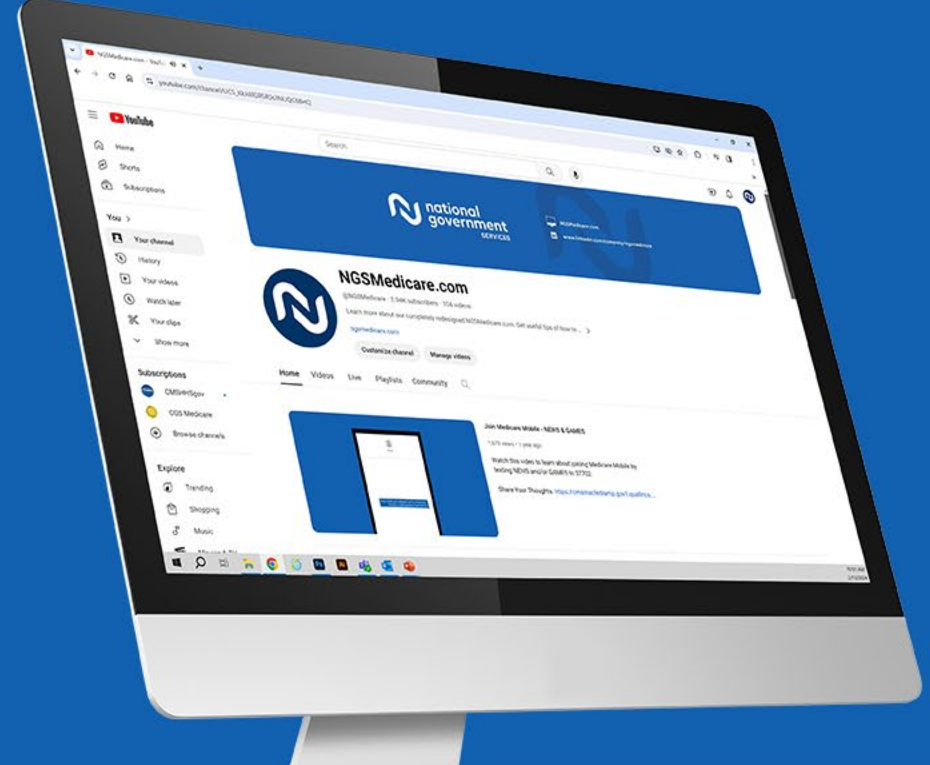
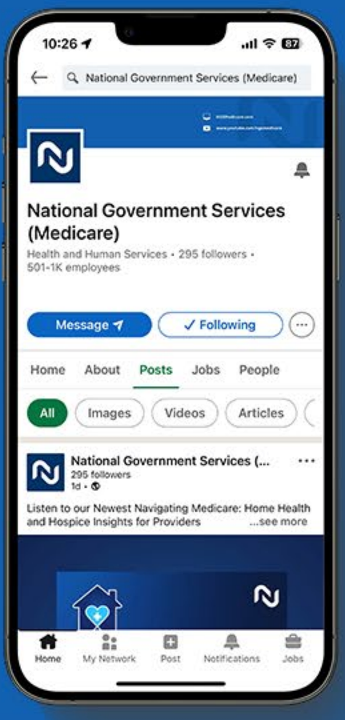
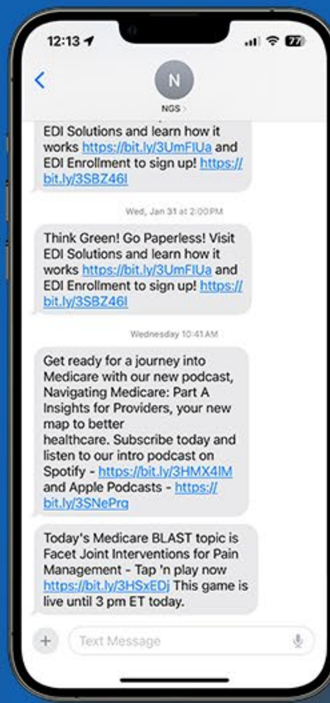
- First Level: NGS Appeals
- Second Level: QIC Appeal
- Third Level: OMHA Appeal
- Fourth Level: Medicare Appeals Council Review Appeal
- Fifth Level: Judicial Review Federal Courts Appeal

Other Resource Material

- NGSConnex
- NCCI Edits
- CMS Medically Unlikely Edits
- Washington Publishing Company

Questions?

Thank you!

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