



## Master the Medicare appeals process

At one point or another, many SNFs will disagree with their fiscal intermediary's (FI), Medicare administrative contractor's (MAC), or carrier's decision to deny a claim. When this occurs, a facility should not hesitate to file an appeal.

"Appealing a denial must be a team effort, involving all facility staff members who participated in billing or providing the service in question," says **Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC**, clinical services consultant at LTC Systems, headquartered in Conway, AR.

Although the individual staff members involved may vary depending on the service or reason for denial, a facility's MDS coordinator, administrator, billers, therapists, and members of the clinical and medical records staff all typically play a role in the appeals process.

Nursing home billers are critical to preventing and identifying denials and gathering information for an

appeal. Since the appeals process can be confusing and time-consuming, SNF billers must have a clear understanding of the system and the important role they play.

### Understand the process

FIs, MACs, and carriers deny claims for several reasons, such as insufficient documentation or the diagnosis code not supporting the medical necessity of the service.

In some situations, the person reviewing the claim could have overlooked important

**"Appealing a denial must be a team effort."**

—*Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC*

information and mistakenly denied it. Regardless of the reason for denial, providers have the right to appeal.

The following are the five levels of the Medicare appeals process:

**1. Redetermination.** The first level of appeal, known as redetermination, must be filed with the FI, MAC, or carrier responsible for the initial determination. Facilities must submit a written request for redetermination within 120 days of receiving the notice of initial determination. Although not required, a request for redetermination can be filed using Form CMS-20027, which can be found on the CMS Web site at [www.cms.hhs.gov/CMSForms/CMSForms](http://www.cms.hhs.gov/CMSForms/CMSForms). The FI, MAC, or carrier has 60 days from receipt of the redetermination request to issue its decision.

**2. Reconsideration.** If it is unsatisfied with the result of the redetermination, a facility can move on to the second level of appeal, known as reconsideration, in which a qualified independent contractor (QIC) reviews the claim.

A facility must file a written reconsideration request with the appropriate QIC within 180 days of receiving the redetermination. The Medicare Redetermination Notice will identify the QIC to which a facility should

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## Appeals process

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submit the request. Although not required, a reconsideration request can be filed using Form CMS-20033, which will be mailed with the Medicare Redetermination Notice. The QIC has 60 days from receipt of the reconsideration request to issue its decision.

**3. Administrative law judge (ALJ) hearing.** The ALJ hearing is the third level of appeal. A written request for an ALJ hearing must be filed within 60 days of receiving the QIC decision. Although not required, an ALJ request can be filed using Form CMS-20034.

To request an ALJ hearing, the amount that remains in controversy must meet the minimum amount requirement, which is adjusted annually (\$120 this year). The ALJ has 90 days to issue a decision. However, if it is

unable to do so, the facility can request that the appeal be escalated to the next level of review.

**4. Medicare Appeals Council.** If it is unsatisfied with the result of the ALJ hearing, a facility can request a review by the Medicare Appeals Council, which is part of the Departmental Appeals Board. The request for a review by the appeals council must be filed within 60 days of receiving the ALJ decision.

The ALJ will provide instructions on how and where to submit a request for an appeals council review. The appeals council has 90 days to issue a decision, and if it fails to do so, the facility may request the council to escalate the appeal to the judicial review level.

**5. Judicial review.** The final stage of the appeal process is judicial review in a U.S. District Court. To request a judicial review, the amount that remains in controversy must meet the minimum amount requirement, which is adjusted annually (\$1,220 this year). A facility must file a request for a judicial review within 60 days of receiving the Medicare Appeals Council's decision.

*Note:* For a chart outlining the Medicare appeals process, see "Medicare appeals process flow chart" on p. 4.

### The biller's role

SNF billers can help their facility avoid denials through accurate coding and ensuring that the documentation supports the services on the claim.

However, avoiding denials altogether would be nearly impossible, and SNF billers should be prepared to identify and respond to denied claims.

FIs, MACs, and carriers communicate claim determinations to providers using a notice called remittance advice. Remittance advice notices are issued daily and are usually sent to a SNF's business office.

"Remittance advice contains codes indicating the status of the claims, and since billers are typically the ones reviewing this notice, they must look out for denial codes," says **Andrew B. Wachler**, managing partner at Wachler

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& Associates, PC, in Royal Oak, MI. "If a denial code is overlooked, the facility may miss the deadline to appeal."

Once a biller identifies a denial, he or she should communicate with other staff members involved in billing or delivering the denied service to determine whether the documentation supports a case against the contractor's decision. If so, these staff members should begin to compile the documentation and information needed to request a redetermination.

### Prove your point

"Facility-based billers can be a key resource in gathering the necessary information for an appeal because they know what was billed and why it was billed a certain way," Rubertino says.

If a facility chooses not to use Form CMS-20027 to request a redetermination, the written request must include the following information:

- Beneficiary's name
- Medicare health insurance claim number
- Specific services and/or items being appealed
- Specific dates of service
- Name and signature of the beneficiary or representative of the beneficiary

In addition to the basic information included in the request, facilities should send documentation related to the denial reason and any other information that supports the need for the skilled service during the period in question.

"This is your chance to prove the claim in question is legitimate and should be paid, so make sure you provide all the information that supports the services were required and necessary," Rubertino says. Examples of the additional documentation that may support a claim are:

- Physician orders
- Progress notes
- Therapy evaluations
- MDS assessments
- Documentation to support the codes on each MDS
- Medication and treatment records
- Discharge summary

### Additional tips for success

In addition to gathering the necessary documentation, a facility can improve its chances of success in the Medicare appeals process by:

- **Appealing assertively.** "Claims can be incorrectly denied, and rather than just accept the denial, providers should defend the services they deliver," Wachler says. "If the service delivered was appropriate and necessary, the provider should appeal assertively, even aggressively, to receive the reimbursement they are entitled to."
- **Being organized.** Facilities should have a system in place to keep track of their progress through the appeals process, the documentation submitted, and all deadlines.
- **Requesting help.** "Many facilities don't contact a consultant or attorney until the later levels of the appeals process, when it is too late to submit additional information or documentation," Wachler says. "A facility should consider talking to a consultant or attorney in the beginning to help them lay out a strategic approach to the appeals process." ■

