Medicare Claims Appeals Process--A Refresher

By Kelli Carpenter Fleming

Reprinted with Permission from the *Medical Association of the State of Alabama*

With the increased audit activity we are seeing among the alphabet soup of Medicare contractors—RACs, ZPICs, SMRCs, CERTs, etc.—now appears to be a good time for a refresher on the Medicare claims appeals process. Due to this increased audit activity, more and more claims are being denied, both under pre-payment review and post-payment review. This article provides an overview on the Medicare claims appeals process, as well as some tips and pointers to keep in mind.

Request for Redetermination

A request for redetermination, the first level of appeal, must be filed within 120 days of receipt of a demand letter from the Medicare carrier (or, if no demand letter is received, within 120 days from the date a Medicare remittance advice shows a claim denial). If the request for redetermination is filed within the shorter timeframe of 30 days, recoupment will not be initiated. If the request for redetermination is filed after the 30-day period, recoupment may be initiated, but will be stopped once the appeal has been filed. Interest begins to accrue on the 31st day and continues to accrue, even if an appeal is filed, until the overpayment is repaid or an entirely favorable decision is rendered. Thus, the only way to avoid the accrual of interest completely is to repay the overpayment before the 31st day. However, you still retain appeal rights even if the alleged overpayment has been repaid—you just have to go through the hassle of trying to get the money back from Medicare if a favorable decision is eventually rendered.

To ensure that all the relevant information is included, send a cover letter containing your arguments (with supporting documentation), as well as the request for redetermination form available here.

The first level of appeal is reviewed by the applicable Medicare carrier, which for physicians practicing in Alabama is Cahaba GBA. The Medicare carrier has 60 days to render a decision.

Request for Reconsideration

A request for reconsideration, the second level of appeal, must be filed within 180 days of receipt of a decision by the Medicare carrier on the request for redetermination filing. If the request for reconsideration is filed within the shorter timeframe of 60 days, recoupment will not be initiated. If the request for reconsideration is filed after the 60-day period, recoupment may be initiated, but will be stopped once the appeal has been filed. Interest will continue to accrue, even if an appeal is filed, until the overpayment is repaid or an entirely favorable decision is rendered. Importantly, all information must be presented at the request for reconsideration level of appeal, as new information is generally not allowed to be presented at the following levels of appeal.

To ensure that all the relevant information is included, send a cover letter containing your arguments (with supporting documentation), as well as the request for reconsideration form available here.

The second level of appeal is reviewed by the applicable Qualified Independent Contractor ("QIC"), an independent party hired by Medicare to review second level appeals. The QIC has 60 days to render a decision.

Administrative Law Judge

A request for a hearing before an Administrative Law Judge ("ALJ"), the third level of appeal, must be filed within 60 days of receipt of a decision by the QIC on the request for reconsideration, assuming the monetary thresholds are satisfied. Importantly, there is no opportunity to stop recoupment at this level of appeal. Thus, recoupment will begin and will continue until a favorable decision is rendered or until the full amount of the overpayment and accrued interest has been offset. Interest will continue to accrue at this level of appeal until the overpayment is repaid, offset through recoupment, or an entirely favorable decision is rendered.

To ensure that all the relevant information is included, utilize the ALJ hearing request form available here.

The ALJ hearing is usually conducted by telephone or video conference. By regulation, the hearing is supposed to take place and a decision rendered within 90 days of the appeal request. However, due to backlogs at the ALJ level, it is currently estimated that appeals will not be heard by ALJs for approximately 6-8 years, unless there is Congressional action to resolve the backlog. There is an option to escalate the appeal to the next level if a decision is not rendered timely in light of this delay. However, the success rate for providers at the ALJ level is relatively high, so bypassing this level of review is not always in the provider's best interest. Nonetheless, despite the delay by the ALJ office, recoupment will continue.

Medicare Appeals Council

A request for review by the Medicare Appeals Council ("MAC"), the forth level of appeal, must be filed within 60 days of receipt of a decision from the ALJ, assuming the monetary threshold is satisfied. The MAC is supposed to render a decision within 90 days. However, due to backlogs, MAC decisions are also taking longer to be issued. There is an option to escalate the appeal to the next level if a decision is not rendered timely. However, such escalation is not always in the best interests of providers.

Judicial Review

A request for judicial review by the appropriate federal district court must be filed within 60 days from receipt of the MAC decision, assuming the monetary threshold is satisfied. From this point, the judicial system will oversee the proceeding.

A couple of points to keep in mind with respect to Medicare claims appeals. Be proactive--review the RAC website for approved audit issues, as well as the most-recent OIG Work Plan for target issues. Develop a formal intake and review process for records requests and demand letters. Always respond to records requests in a timely manner, as the failure to do so will result in an automatic claim denial.

Keep track of denied claims and look for patterns. Determine corrective action to take, if applicable, and appeal as necessary and appropriate. If you appeal, file everything by a trackable delivery method and keep copies of all documents that are filed and received. Always ask for confirmation in writing when receiving advice or instruction from the applicable review body.

While the claims appeal process can be frustrating, time-consuming, and costly, providers tend to have a high degree of success. However, many providers simply pay the overpayment amount without challenging the finding due to the associated time and expense. Depending on the amount of the overpayment and the frequency with which you believe the pertinent issue has occurred within your practice, spending the time and effort to appeal may be beneficial.

For more information, please contact:

Kelli Carpenter Fleming
Partner, Birmingham Office
Phone (205) 458-5429
E-Mail kfleming@burr.com

Kelli Fleming is a partner at Burr & Forman LLP who works exclusively within the firm's Health Care Practice Group.