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The Medicare Appeals Process: What You Need to Know

5/21/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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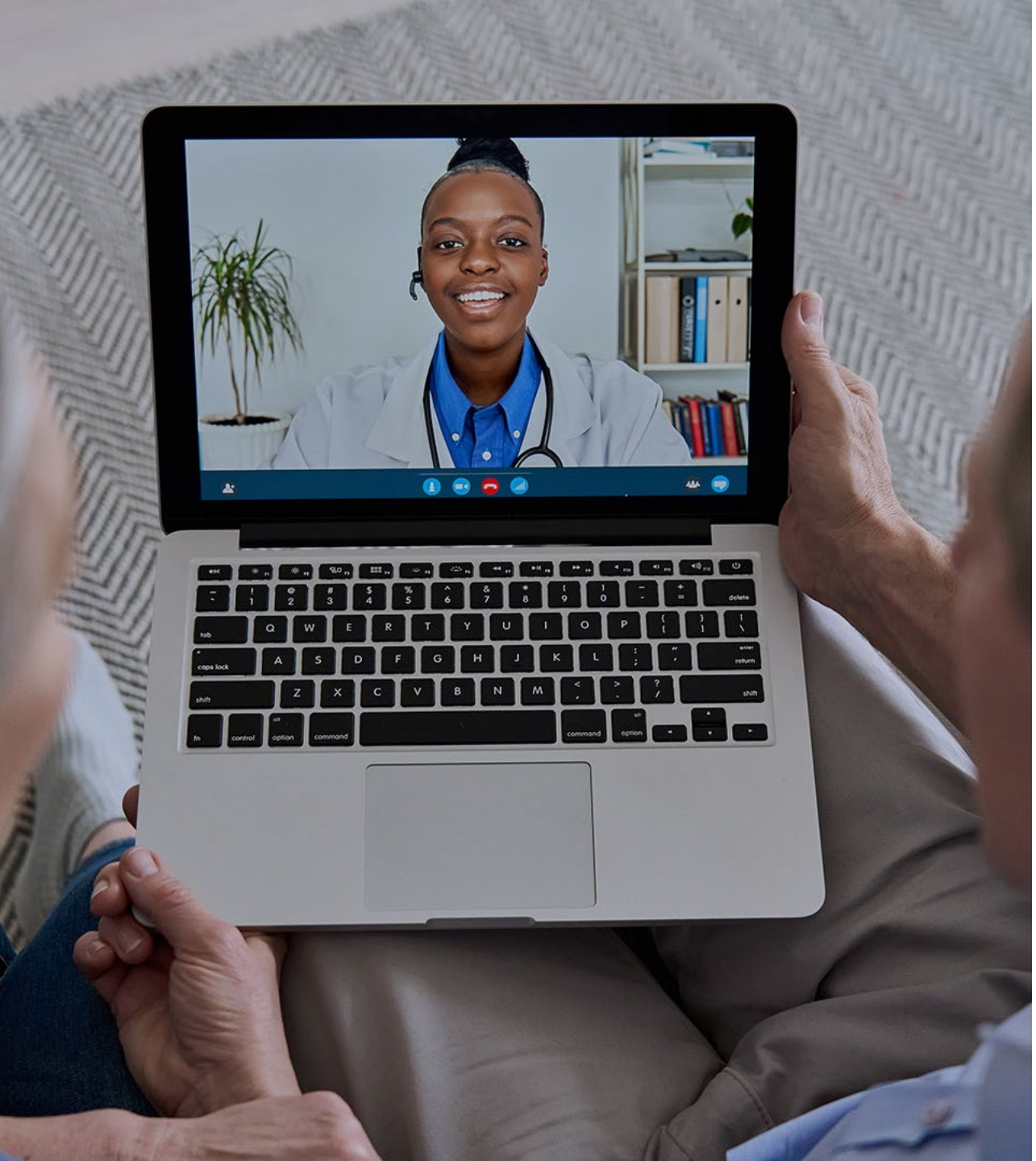

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Objective

After this session, attendees will have the knowledge needed to successfully navigate Medicare's appeals process and know where to go to find more information.

Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Jeanine Gombos

Agenda

- Reopenings
- Appeals Process
- Appeal Levels
- References and Resources
- Questions

Reopenings

What Is a Reopening?

- Request to reopen claim to correct clerical errors/omissions
  - Action to change initial determination **outside of appeals process**
- Submit single reopening request if reopening for multiple services on same claim (same DCN)
- Request within one year of claim's finalized date
- Occurs at NGS's discretion
  - If we decide not to reopen claim, decision not appealable

A reopening is not an appeal

Valid Reopening Reasons

- Include:
  - Human or mechanical error
  - Mathematical or computational mistake
  - Transposed codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items
    - Provider number
    - Use of modifier
    - DOS
- Does not include:
  - Omissions or failure to bill for items or services
  - Third-party payer errors

Reopening of Partially Denied Claims

- Providers can reopen claims partially denied by automated edits for LCDs/NCDs to add/change diagnosis code(s)
  - Line-item denial reason code(s) 55A00, 55A01, 52NCD, 53NCD, 54NCD or 59xxx series
- To submit reopening request or adjustment (LN adjustment process)
  - Adjustment TOB = XX7 or XXQ
  - Adjustment reason code = LN
  - Adjustment CC = D9
  - Add/change diagnosis code
    - Must justify services automatically denied due to lack of appropriate diagnosis code per LCD/NCD

Other Types of Reopenings

- To reopen claims partially denied for other valid reasons
  - Submit reopening request or adjustment (regular adjustment process)
    - Adjustment TOB = XX7 or XXQ
    - Adjustment reason code = As applicable
    - Adjustment CC = As applicable
    - Make necessary correction (must be clerical error/omission, e.g., correct HCPCS code)
- To reopen claims fully denied
  - Claim status/location in FISS = DB9997
  - Submit reopening request; not adjustment

Reopening Request Options

- Via NGSConnex (preferred)
  - Refer to “Initiate a Clerical Error Reopening” instructions in *NGSConnex User Guide*
- In writing
  - Complete Clerical Error/Omission Reopening Request Form
  - Include:
    - Beneficiary’s name and Medicare number
    - Date of initial determination notice
    - DOS
    - Specific clerical error/omission change you would like considered
    - Requestor name, address, telephone number and relationship to beneficiary
    - NPI, PTAN and tax ID
    - Requestor’s signature and date
    - Any necessary documentation

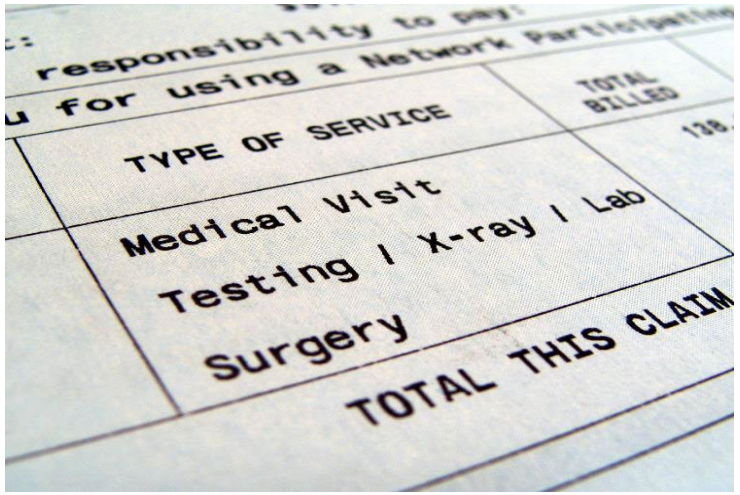
Reopening/Adjustment References

- Submit Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials
- Reopenings for Minor Errors and Omissions
  - When mailing reopening request, use correct P.O. Box listed on bottom of form

JK Part A Providers	J6 Part A and FQHC/RHC Providers
National Government Services Appeals Dept. P.O. Box 7111 Indianapolis, IN 46207-7111	National Government Services Appeals Dept. P.O. Box 6474 Indianapolis, IN 46206-6474

Appeals Process

Overview



Review Claim Decisions Carefully

Providers and beneficiaries should review claim results and determine if they want to appeal

Ensure Correct Claim Adjudication

Providers and beneficiaries have right to appeal most claim determinations made by NGS

CMS Governs All Appeal Activities

Appeals process and activities are governed by CMS

What Is an Appeal?

- Action you can take if you disagree with Medicare's coverage or payment decision
- Applies to most fully or partially denied claims
  - Review reasons for claim or claim line denial to determine if appealable
    - "Remarks" on claim in FISS
    - Claims determination letter(s)

Who Can Submit an Appeal?

- Can be requested by
  - Provider
  - Beneficiary
  - Beneficiary's authorized representative (such as family member or attorney)
- Representative may be appointed at any point in appeals process
  - CMS Appointment of Representative Form (CMS 1696)
    - Valid for one year from date signed by party making appointment, or date appointment accepted by representative, whichever is later

Examples of Possible Appealable Situations

- Coverage/medical necessity
- Deductible or coinsurance amount
- Number of days used for hospital or post-hospital extended care
- Physician certification requirement
- Beginning and ending of benefit period
- Determination of limitation of liability provision
- Issue affecting amount of benefits payable (including over- and under-payments)
- Pre-payment/post-payment probes (CERT, UPIC, SMRC, RA, QIO)

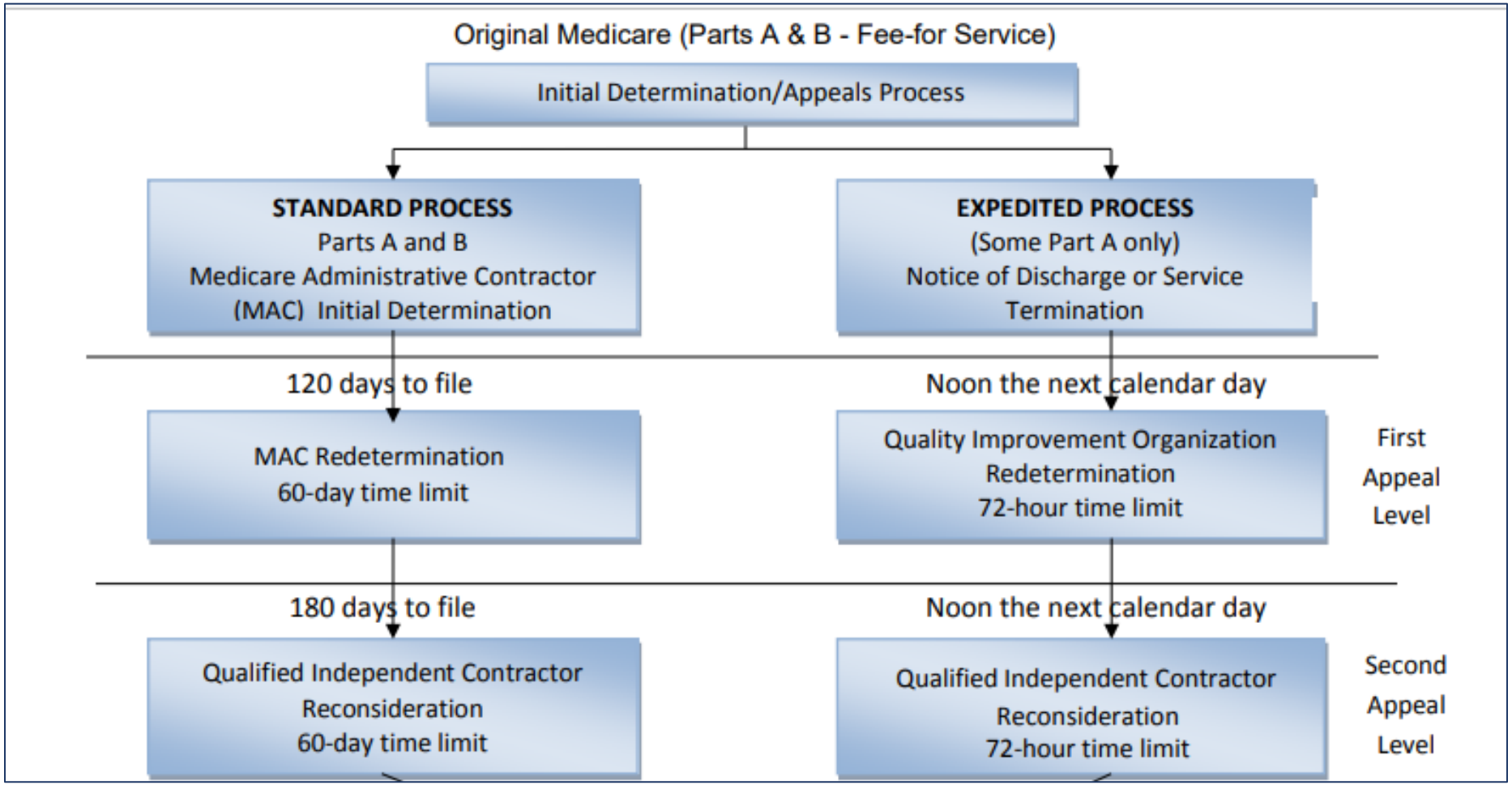
Do Not Appeal - Primary Claims Rejected for MSP

- Claims submitted as Medicare primary reject for MSP (cost-avoid) if both apply:
  - Open MSP record in CWF exists
  - Claim does not indicate why Medicare primary
- Determine correct primary payer and submit subsequent adjustment depending on situation
  - Other payer primary
    - Bill primary payer
    - Once response received, submit adjustment to Medicare to change claim to MSP (or conditional)
  - Medicare primary
    - Have beneficiary contact BCRC, if applicable, to have MSP record corrected
    - Once correction complete, submit adjustment to make Medicare primary

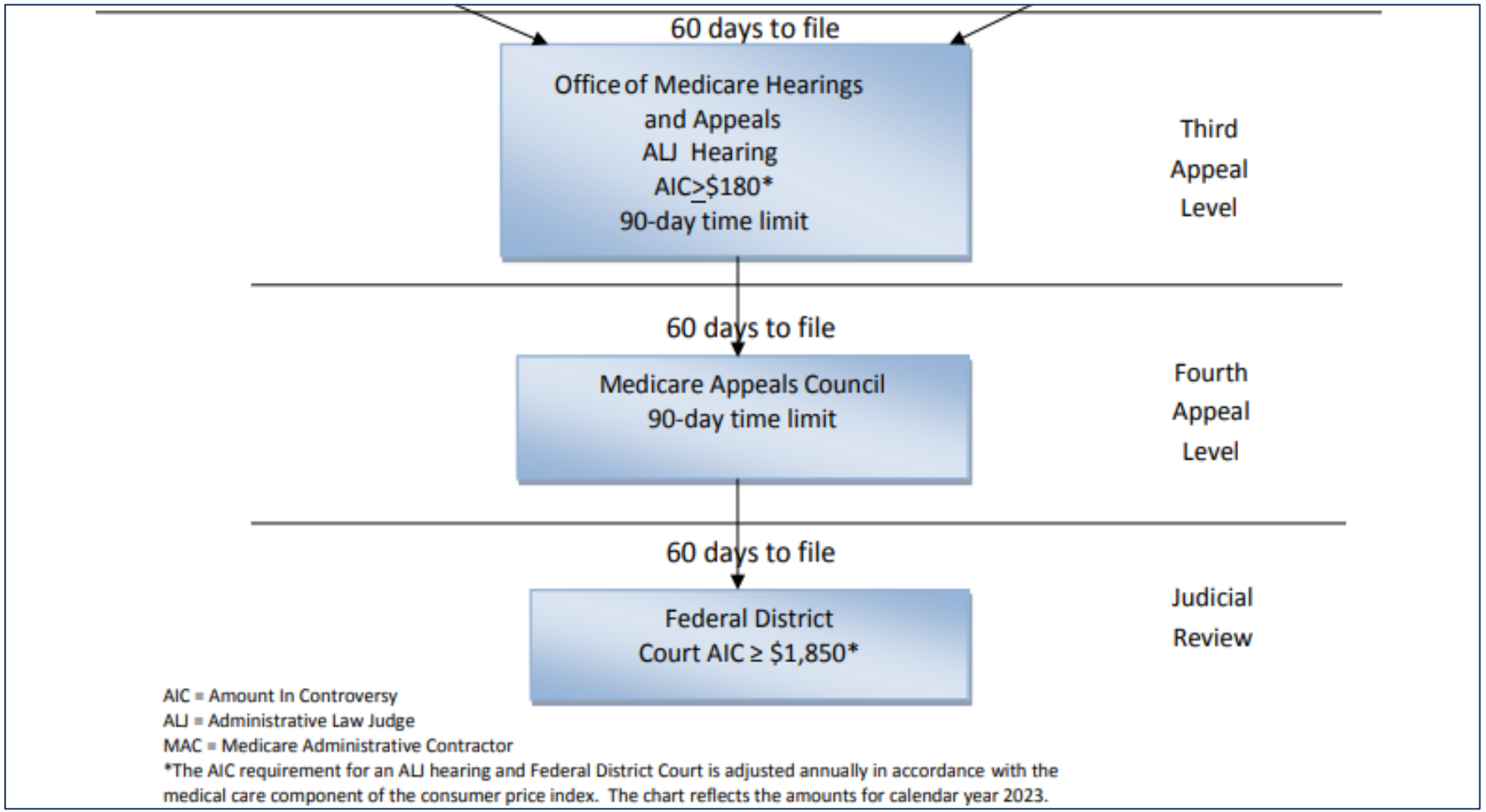
Do Not Appeal - Claims Rejected for Timely Filing

- Federal regulations mandate timely filing of claims within 365 days from DOS
- Determining if claim filed timely
  - Generally, claim “From” date used
  - Institutional claims that span DOS - “Through” date used
- Four exceptions
  - Refer to Claim Timely Filing Job Aid
  - Determine if exception met and submit adjustment if applicable

Medicare FFS Appeals Flow Chart – Part 1



Medicare FFS Appeals Flow Chart – Part 2



Amount in Controversy (AIC)

- Certain appeal levels must meet monetary threshold/AIC
  - May be able to aggregate claims
  - AIC thresholds updated annually
- AIC determined by
  - Actual amount charged for items and services in question, reduced by
    - Medicare payments already made or awarded for items or services
    - Deductible and coinsurance amounts applicable

Timely Filing of Appeals

- If you cannot file appeal within necessary timeframe, you can request extension
  - Granted by Appeals staff
  - Based on “good cause”
  - If approved, does not grant extension on next appeal level
  - When good cause not established, request dismissed
    - If you disagree with dismissal, you must file next level of appeal request within appropriate timeframe from dismissal date

Did You Know?

- Failure of billing company or other consultant to timely submit appeals or other information is **not** grounds for finding good cause for late filing!

Examples of Good Cause

- Serious illness prevented you from contacting appeals reviewer
- Death or serious illness
- Important records destroyed or damaged by fire or other event
- Access to records affected by emergency or disaster
- Contractor or reviewer provided incorrect or incomplete information about when and how to file appeal
- Notice of determination or decision not received
- Submitted request to government agency in good faith within time limit but didn't reach appeals representative in time
- Delay because documents needed in large print, braille or other format
- Physical, mental, educational or other limitations

Appeal Levels

Level One: Redetermination

- Submitted to National Government Services
- Time limit to initiate redetermination
  - 120 days from receipt date of initial determination
- Time limit to complete review
  - 60 days
- Amount in controversy
  - No minimum
- Part A Redetermination Request Form Level 1

Tip: One Appeal Request Per Claim

- Submit one redetermination request per claim
  - Do not submit request for each line
  - Only one claim per Redetermination Request Form
  - In NGSConnex, only claim indicated in "Redetermination Details" considered
    - Do not submit additional claims to be considered in "Attachments" section
- If appeal request involves overpayment determined through sampling and extrapolation
  - Identify all contested sample claims in one request and state any sampling methodology challenges

What to Include in Redetermination

- Must include
  - Beneficiary's name
  - Beneficiary's Medicare number
  - Specific service/item provided and DOS
  - Name and signature of person requesting appeal
  - Attachments for additional information
  - All pertinent supporting medical record documentation (signed by physician)
  - Explanation of delayed request if submitting past time limit
- Make sure to include point of contact information
  - Someone who will respond promptly to document requests

Tip: Documentation

- When requesting appeal, submit complete medical record
  - Determine type of documentation to submit
    - Previously sent records automatically incorporated; do not resend
  - Refer to What Documents are Needed
    - Listing of types of services you may appeal and medical records that may assist in supporting that services billed are coverable by Medicare
  - Include relevant supporting documents, for example:
    - Copy of decision letter(s) or claim information issued at prior level(s), if applicable
    - Copy of demand letter(s) if appealing overpayment determination

Submit Redetermination in Writing

- **Part A Redetermination Request Form Level 1**
  - Type appropriate information into form or ensure handwriting legible
  - Complete all areas of form
    - Include attachment if more space needed
  - Attach necessary documentation
- Mail to correct address

JK Part A Providers	J6 Part A and FQHC/RHC Providers
National Government Services Appeals Dept. P.O. Box 7111 Indianapolis, IN 46207-7111	National Government Services Appeals Dept. P.O. Box 6474 Indianapolis, IN 46206-6474

Tip: Protect PHI

- When using FedEx, UPS and/or USPS
  - Add cover sheet indicating package contains PHI and include all necessary disclaimers
  - Label boxes and envelopes clearly
  - Use reinforced boxes and secure with shipping tape
  - Confirm unrelated information not included within package/envelope

Submit Redetermination in NGSConnex

- Access NGSConnex
  - Log in to NGSConnex with your username and password
  - Follow instructions in the *NGSConnex User Guide* to submit redetermination and supporting documentation
- Submit only documentation relevant to services/dates in your request
  - Submit as few attachments as possible by combining multiple supporting documents into each attachment
    - Attachment maximum size 25 MB each
    - File types not accepted = .xml, .log, and .cfg

Tip: Do Not Submit Duplicate Requests

- Check if you previously submitted reopening/redetermination via NGSConnex by verifying Submission History
  - Submission History panel displays reopening submitted via NGSConnex on/after 2/25/2022
- Submitting duplicate reopening/redetermination requests
  - Results in processing delays
  - Abusive and costly to Medicare Program

Submit Redetermination via esMD

- Electronic Submission of Medical Documentation (esMD)
  - CMS-developed mechanism for contractors to receive redeterminations electronically via secure gateway
- To electronically submit redetermination to NGS
  - Build a gateway or
  - Procure gateway services from HIH of your choice
- Include completed/signed **Part A Redetermination Request Form Level 1**
  - First page of submission

Level Two: Reconsideration

- Submitted through QIC assigned by CMS
- Time limit to initiate reconsideration
  - 180 days from receipt date of redetermination decision
- Time limit to complete review
  - 60 days
- Amount in controversy
  - No minimum
- Medicare Reconsideration Request Form (CMS 20033)

Reconsiderations – JK Part A Providers

- C2C Innovative Solutions, Inc. (C2C)
- Questions on QIC Part A East
  - Call 904-224-7446
- Ways to submit reconsiderations to C2C
  - US Mail

    C2C Innovative Solutions, Inc.
    QIC Part A East Appeals
    P.O. Box 45305
    Jacksonville, FL 32232-5305
  - Secure fax 904-539-4074
  - C2C Appeals Portal

Reconsiderations – J6 Part A and FQHC/RHC

- Maximus, Inc.
- Questions on QIC Part A West
  - Call 585-348-3020 and leave message
- Ways to submit reconsiderations to Maximus
  - US Mail

    QIC Part A West
    Maximus, Inc.
    Medicare Part A West
    3750 Monroe Ave. Suite 706
    Pittsford, NY 14534-1302
  - Secure fax 585-869-3346
  - QIC Appeals Portal

Level Three: ALJ

- Time limit to initiate appeal to ALJ
  - 60 days from receipt date of reconsideration from QIC
- Time limit to complete review
  - 90 days
- Amount in controversy (updated annually)
  - $190 minimum (2025)
- Request for ALJ Hearing or Review of Dismissal (Form OMHA-100)

Aggregating Claims to Meet Threshold

- To meet threshold amount, two or more claims previously reconsidered by QIC can be aggregated in request for ALJ hearing
  - Can include both Part A and Part B claims
- Can be done by individual appellant or multiple appellants
  - Individual – All aggregated claims involve delivery of similar/related services
  - Multiple – All aggregated claims involve "common issues of law and fact"
- Request for ALJ hearing must be properly filed within 60 days after receipt of all appealed reconsiderations
  - List all claims to be aggregated
  - Include reasoning why claims included involve "common issues of law and fact" or similar/related services

ALJ – Part A and FQHC/RHC

- Through US Department of HHS Office of Medicare Hearings and Appeals (OMHA)
- For questions on ALJ process
  - Call 855-556-8475 or email Medicare.Appeals@hhs.gov
- Ways to submit ALJ appeal requests
  - US Mail

    OMHA Central Operations
    1001 Lakeside Avenue, Suite 930
    Cleveland, OH 44114-1158
  - OMHA e-Appeal Portal
- Check status via ALJ Appeal Status Information System (AASIS)

Level Four: Medicare Appeals Council

- Through DAB
- Time limit to initiate appeal to DAB
  - 60 days from receipt date of ALJ decision
- Time limit to complete review
  - 90 days
- Amount in controversy
  - No minimum
- Request for Review of ALJ Medicare Decision/Dismissal (Form DAB-101)

DAB – Part A and FQHC/RHC

- Appeals to the Medicare Appeals Council (Council)
- For questions on DAB Medicare appeals process, call
  - Local: 202-565-0100
  - Toll free: 866-365-8204
- Ways to submit DAB Medicare appeals requests
  - US Mail

    Department of Health & Human Services
    Departmental Appeals Board, MS 6127
    Medicare Operations Division
    330 Independence Ave., S.W.
    Cohen Building, Room G-644
    Washington, DC 2020
  - Fax 202-565-0227
  - DAB Medicare Operations Division eFile

Level Five: Judicial Review

- Through Federal U.S. District Court
- Time limit to initiate Judicial Review appeal
  - 60 days from receipt date of Medicare Appeals Council DAB decision
- Time limit to complete review
  - None
- Amount in controversy (updated annually)
  - $1,900 (2025)
- No official form required
  - Suggest submission of all other forms for appeals level one to four

Federal U.S. District Court – Part A and FQHC/RHC

- Do not send to National Government Services!
- File in appropriate district court of the United States
  - Judicial district in which appealing party resides or where individual, institution, or agency has principal place of business

Five Levels of Appeal Recap

Appeal Level	Monetary Threshold 2024	Monetary Threshold 2025	Time Limit for Filing	Forms
Redetermination	None	None	120 days from RA receipt date	Part A Redetermination Request Form Level 1
Reconsideration	None	None	180 days from redetermination notice	Medicare Reconsideration Request Form (CMS 20033)
ALJ Hearing	$180	$190	60 days from reconsideration notice	Request for ALJ Hearing or Review of Dismissal (Form OMHA-100)
DAB Review	None	None	60 days from ALJ decision	Request for Review of ALJ Medicare Decision/ Dismissal (Form DAB-101)
Judicial Review	$1,840	$1,900	60 days from DAB decision	No official form

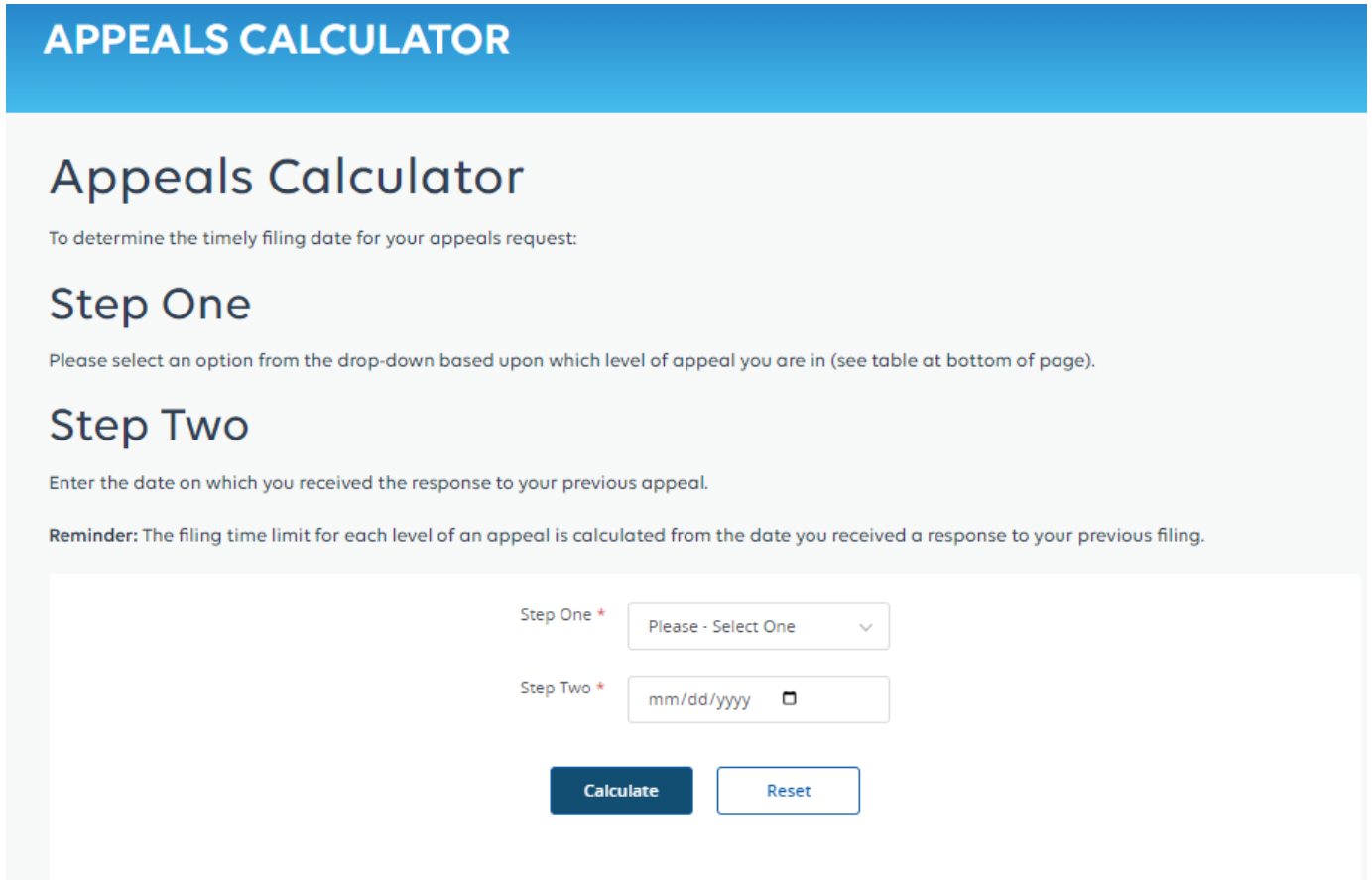
Appeal Tips

- Remember to be
  - Timely and valid in submission
  - Appropriate in submission
  - Patient
  - Forthcoming for future contact
  - Prompt
  - Thorough

References and Resources

Tool: NGS Appeals Calculator

- Visit our website > Resources > Tools and Calculators > Appeals Calculator

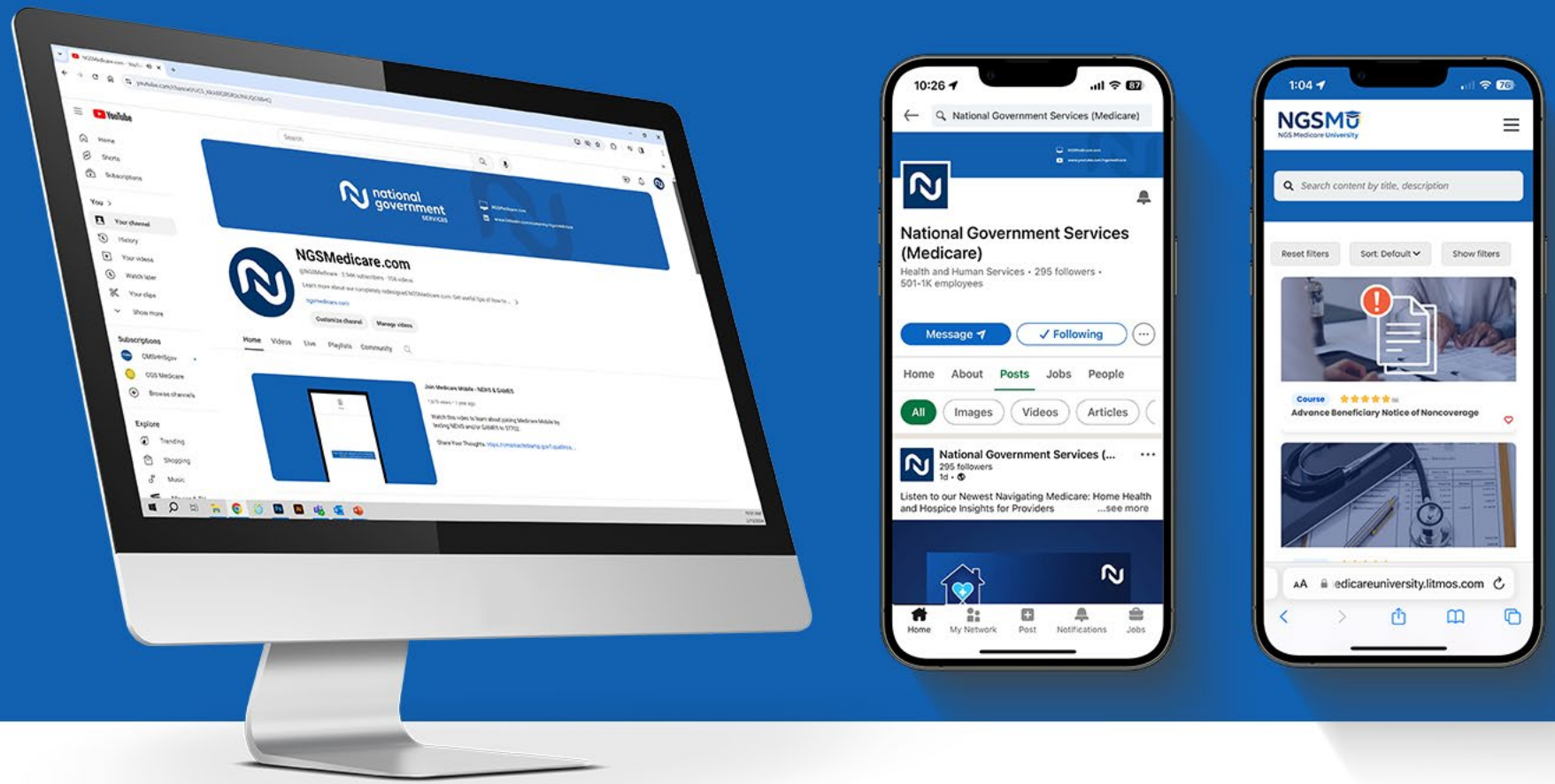


CMS References and Resources

- Original Medicare (Fee-for-service) Appeals Levels
- CMS FFS Appeals Flow Chart
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 29 – Appeals of Claims Decisions
- 42 CFR Part 405 Subpart I - Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare (Part A and Part B)
- MLN® Booklet: *Medicare Parts A & B Appeals Process*
- MLN® Fact Sheet: *Medicare Overpayments*
- MLN Matters®: *MM13846 Medicare Change of Status Notice Instructions*

NGS References and Resources

- Reopenings for Minor Errors and Omissions
- About Appeals
- Levels of Appeals and Time Limits for Filing
- NGS Appeals Forms
- What is NGSConnex?
- News Articles
  - Appealing a Denied Claim
  - Providers Using NGSConnex to Submit Appeals and Supporting Documentation



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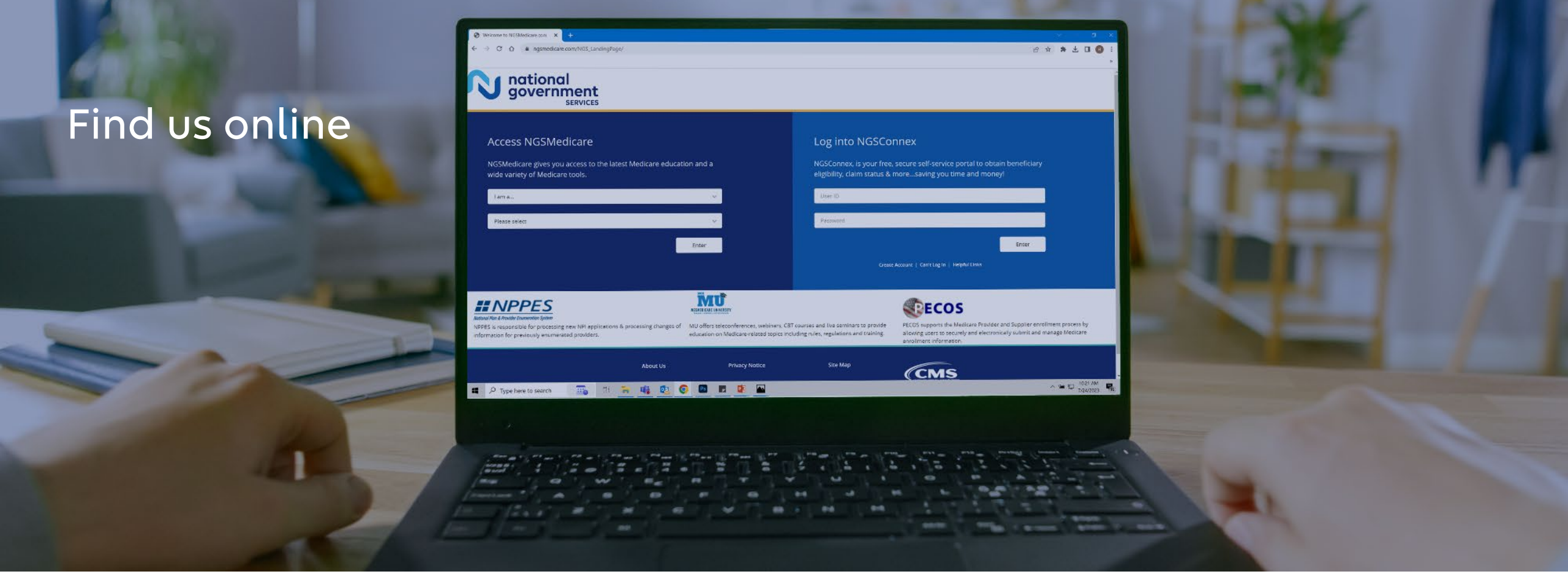

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[IVR System](#)
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

[NGSConnex](#)
Web portal for claim information

[Sign up for Email Updates](#)
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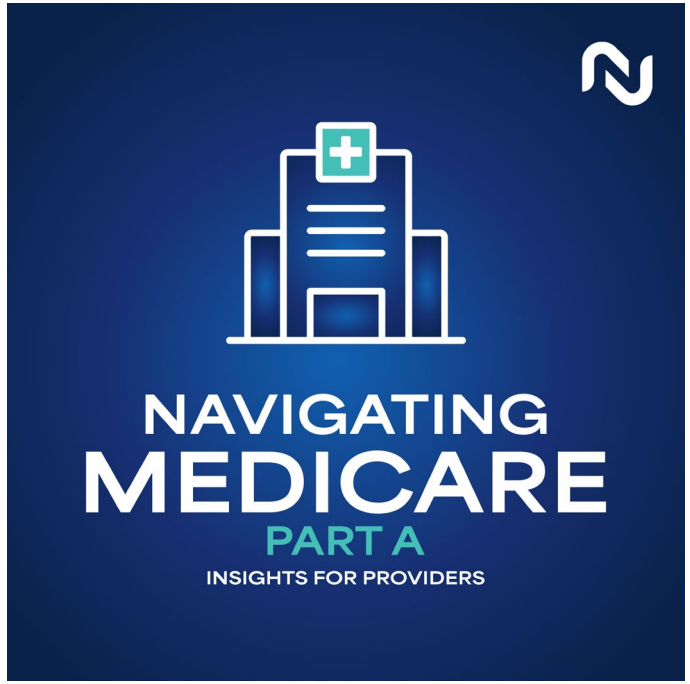

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Questions?

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