



Quick Reference Guide for Appeals



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I. Adjustments via Direct Data Entry (DDE)

Part A providers that are able to submit an adjusted or corrected claim in FISS via DDE to correct an error or omission are encouraged to follow this process and are not required to request a redetermination or clerical error reopening. This is the most efficient way to correct simple errors. The type of bill (XX7), claim change reason code and adjustment reason codes must be used. See the Quick Reference Guide for Filing Adjustment and Cancel Claims at

<http://www.highmarkmedicareservices.com/parta/selfservice/pdf/gr-filingadjcancelclms.pdf> .

However, the DDE adjustment process cannot be utilized to adjust claims that are denied on the basis of medical review (e.g., 56900, 50017, 50174, 59174, 50NRL, 50MIS reason codes).

This process is also not appropriate for denials based on Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) policies (e.g., 5ARAN, 5RRAN, 54NCD reason codes) due to the reported diagnosis or the frequency of the service.

Additionally, a provider should NOT submit a redetermination or clerical error reopening request and perform an adjustment via DDE on the same claim at the same time.

II. What is not a Redetermination Request?

The Appeals Department sometimes receives redetermination requests that are not appropriate for the redetermination process. Please review the following issues to ensure that your redetermination requests are valid.

A. Claim Not Finalized

A claim must be finalized before a redetermination request can be submitted. Do not submit a redetermination request if an initial claim has not completed processing or an adjustment claim (TOB XX7) has not completed processing.

B. Unprocessable Claim

A claim that is rejected with message **MA-130** (Your claim contains incomplete and/or invalid information and no appeal rights are afforded because the claim is unprocessable) must be resubmitted as a new claim with the correct/complete information. Do not submit a redetermination request.

C. OCE Rejected Service (W70XX reason codes)

For an OCE rejected service(s), in most cases, providers should submit an adjustment claim (TOB XX7). Submitting an adjustment claim is the most efficient way to correct these types of issues.

Providers need to understand the Outpatient Code Editor (OCE) package to determine whether a “W” reason code can be adjusted or appealed. See CR6080 (July 2008) to view a list of the “W” reason codes and the actions that providers can take when a service(s) is denied based on the OCE. This may be viewed on the CMS internet site at <http://www.cms.hhs.gov/Transmittals> . Note: The OCE package is updated quarterly and CMS issues quarterly transmittals that explain the updates. The next update will be **April 2009**.

CMS also maintains an interactive web based tutorial on the MLN internet site. We encourage you to check it out. It may be found at <http://www.cms.hhs.gov/MLNGenInfo/>

D. Rejected Claims Due to Other Billing Errors

Claims that have been rejected due to billing errors such as failure to report a modifier should be adjusted by the provider to correct the claim (e.g., V8022, V8024 reason codes due to failure to report the KX modifier if appropriate).

E. Non-covered by the Provider (reason codes **31305, 31992, 31993, 31947)**

Line items that are billed as non-covered by the provider can usually be corrected by submitting an adjustment bill (TOB XX7) to correct the claim.

III. Five Levels of Appeal

A party dissatisfied with the initial determination on a claim is entitled by law and regulations to specified appeals. The following chart provides you with an overview of the five levels of appeal.

Level of Appeal	Time Limit for Filing a Request	Monetary Threshold to be Met
1. Redetermination by the Medicare Contractor	120 days from the date of the initial determination	None
2. Reconsideration by a Qualified Independent Contractor (QIC)	180 days from the date of the Medicare Redetermination Notice	None
3. Hearing by an Administrative Law Judge (ALJ)	60 days from the date of receipt of the Reconsideration Notice	At least \$120.00* remains in controversy
4. Review by the Medicare Appeals Council (MAC) of the Departmental Appeals Board (DAB)	60 days from the date of receipt of the ALJ decision	None
5. Judicial Review in U.S. District Court	60 days from the date of receipt of the MAC decision	At least \$ 1,220.00 * remains in controversy

*The amount in controversy requirement is increased annually by the percentage increase in the medical care component of the consumer price index. The amounts shown are requests received on or after January 2009.

The Medicare Learning Network has developed a brochure titled **The Medicare Appeals Process**. It provides more detailed information on all the levels of the appeals process. It may be downloaded at the following web site:

<http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>

The primary purpose of this **Quick Reference Guide for Appeals** is to provide you with information regarding clerical error reopenings and the first level of appeal, a redetermination, performed by Highmark Medicare Services.

IV. Clerical Error Reopenings

CMS Publication 100-4, Chapters 29 & 34 and MLN article MM 4147 – Reopenings and Revisions of Claim Determinations and Decisions

Section 937 of the Medicare Modernization Act required The Centers for Medicare & Medicaid Services (CMS) to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. CMS believes that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process.

CMS defines clerical errors (including minor errors or omissions) as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer errors;
- Denial of claims as duplicates which the party believes were incorrectly identified as a duplicate; or
- Incorrect data items, such as provider number, use of a modifier or date of service.

Note that clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. A reopening shall not be granted to add items or services that were not previously billed. Third party payer errors do not constitute clerical errors.

Examples of issues that may **not** be handled as a clerical error reopening are as follows:

- **Inpatient services (e.g., hospital, SNF inpatient, inpatient rehab facility or IRF)**
- Limitation of liability issues;
- Initial claim determinations issued as a result of the following:
 - Prepay MR review, e.g., reason code denials to include but not limited to 50017, 50174, 59174, 50MIS;

- Comprehensive Error Rate Testing (CERT) denials (TOB is XXH);
- Program Safeguard Contractor (PSC) denials;
- MSP issues (Note: third party payer errors do not constitute clerical errors);
- The addition of lines or items that were not previously billed;
- The additional diagnosis/data does not permit payment of the claim; or
- The denial(s) is solely the result of an OCE rejection edit that can be corrected by the provider via Direct Data Entry (DDE).

Direct Data Entry vs. Clerical Error Reopening

REMINDER: The clerical error reopening process does not replace the submission of an adjustment or corrected claim via Direct Data Entry (DDE) in FISS. The DDE adjustment should be submitted whenever possible since it is the most efficient way to correct simple errors. The Clerical Error Reopening Request Form should only be used for those situations where you are unable to do the DDE adjustment. See Section I – Adjustments via Direct Data Entry.

Highmark Medicare Services has developed a form for requesting a clerical error reopening. Use of the clerical error reopening form will expedite your reopening requests. The form is located at

<http://www.highmarkmedicareservices.com/parta/forms/pdf/medicare-reopening-request-form.pdf>

Medical records are not required however a corrected UB-04 claim form is required to be submitted with your clerical error reopening request. Circle or highlight the change(s) that you are requesting. Your medical record documentation must support the changes you are making and be available for review upon request.

If the changes you are requesting do not allow payment of the claim, your request for a clerical error reopening will not be accepted. A clerical error reopening is a discretionary action on the part of a Medicare contractor. The decision not to reopen a claim cannot be appealed. You may request a redetermination on the original claim if appeal rights were given, but you must do so within the required time frame of 120 days from the date of receipt of the initial determination notice.

IMPORTANT: Requesting a reopening does not toll the timeframe to request a redetermination.

V. Redetermination – First Level of Appeal

CMS Publication 100-4 (Medicare Claims Processing Manual), Chapter 29 Section 310

The first level of appeal is a redetermination. A redetermination is an independent reexamination of a claim. A redetermination can be requested if you are dissatisfied with the initial processing of your claim. A redetermination must be filed within 120 days of the date of receipt of the initial claim determination notice. All requests for

redeterminations must be filed in writing. Regulations dictate that requests for redeterminations may not be filed over the telephone.

Effective May 1, 2005, Medicare providers who submit claims to a Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC) have the same right to appeal claims as beneficiaries. This means the provider does not need to submit an Appointment of Representative form with an appeal request.

Highmark Medicare Services has developed the **Medicare Part A Redetermination Request Form** for your use. This form is located on the Highmark web site at <http://www.highmarkmedicare.com/parta/forms/pdf/med-a-redetermination-request-form.pdf>. A Medicare Redetermination Request form should be completed for each claim in question.

All written requests for a redetermination **must** contain the following items:

- The beneficiary name;
- The beneficiary Medicare number;
- The specific service(s) and/or item(s) for which the redetermination is being requested;
- The specific date(s) of service; and
- The printed name and signature of the requestor.

Your appeal request will be dismissed if any of the above information is not included with the request (Medicare Claims Processing Manual, Chapter 29, Section 310.1B2).

Additionally, if there are multiple denied lines on the claim, but you are only questioning/disputing one line, please be explicit in what you are requesting that we review.

VI. Documentation to include with your Redetermination Request

Redetermination requests must include all pertinent medical documentation pertaining to the services in question. The medical record documentation must include the patient's name and must be complete and legible. If you are making changes to the claim, include a copy of a revised UB-04 claim form. In addition, if an Advance Beneficiary Notification (ABN) or other beneficiary notice was issued, include a copy of this document.

Remember that medical record documentation must be legible. Each page of the record should identify the patient and the date. A hand written or electronic signature and credentials should follow each record entry (stamp signatures are not acceptable). The record should be of good copy quality for review purposes.

Effective August 1, 2008, Highmark Medicare Services will not routinely request additional inpatient documentation from providers who failed to submit all the necessary medical records. The redetermination will be performed based on the medical record documentation that you submitted with your appeal request. Providers, physicians and

other suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.

If the service being appealed was denied due to a Local Coverage Determination (LCD), you should review the LCD policy for the documentation requirements that are necessary to support the service. The LCDs are available on the Highmark internet site at <http://www.highmarkmedicareservices.com/parta/index-medpolicy.html> .

If the service being appealed was denied due to a National Coverage Determination (NCD), you should review the NCD policy for the documentation requirements that are necessary to support the service. The NCDs are available at <http://www.cms.hhs.gov/CoverageGenInfo/>

The following list may be used as a guideline (not all-inclusive) when submitting documentation with your redetermination request.

Issue	Documentation
Clinical laboratory services	Physician orders or office notes indicating clinical indications for the testing and the laboratory report
Cosmetic Surgery (e.g., blepharoplasty, breast reduction)	Physician notes/consultation report, visual fields, photographs, operative report, pathology report
Dental Services	Physician notes, operative report, pathology report
Dialysis	Physician orders, dialysis flow sheets and all medical record documentation that supports the clinical indication for the number of dialysis sessions
Erythropoietin (EPO)	Office notes, medication administration record and lab results
Evaluation and Management (E/M) services	Physician's notes or progress notes; consultation report
Injections	Physician orders, physician notes regarding patient's clinical status, medication administration record, effectiveness of ongoing drug therapy, documentation of waste, as appropriate
Injections, chemotherapy	Physician orders, physician notes regarding patient's clinical status, medication administration record, documentation of waste as appropriate, and current drug studies if for an off-labeled indication
Inpatient Hospital Services	History of patient's condition and reason for admission, H&P, physician orders, physician and nursing progress notes, medication and treatment records, operative reports
Inpatient Rehabilitation Facility (IRF) Services	Physician order for admission/transfer to an IRF, pre-admission assessment or H&P, discharge assessment, all discharge summaries, physician and nursing progress notes, all consults ordered during the admission, all evaluations (e.g., therapy, bowel/bladder,

Issue	Documentation
	nutritional), all therapy progress notes and time logs, multidisciplinary team and conference notes, PAI or PT/OT/RN individualized FIM Motor Scores
Inpatient Skilled Nursing Facility (SNF) Services	Certification/Recertification, physician orders, physician and nursing progress notes, therapy evaluations and treatment plans (if applicable), all MDS assessment(s) appropriately dated, documentation for the look back period for each MDS, medication and treatment records, decubitus records (if applicable), and hospital transfer sheet, history and physical, discharge summary and any applicable surgical reports
Physical, Occupational and Speech Therapy Outpatient Services	Physician order, certifications/recertification, treatment plan, evaluation (or reevaluation), treatment notes, interval progress reports, and reported treatment minutes to support the number of units billed for each service on the claim
Radiology Services	Physician orders/office notes that indicate the clinical indications for the test and the radiology report

An appeal request for a claim that was denied by Medical Review (MR) for insufficient documentation must be submitted with all the medical record documentation that was requested in the additional documentation request (ADR). The ADRs that you receive requesting supporting documentation are very specific regarding the type of information that is required. Thoroughly review the ADR to be sure that all items requested in the ADR have been submitted with your appeal request.

Please review Provider Notice 06-066 regarding the need for accurate, complete, and timely responses to ADRs. It is located on our internet at <http://www.highmarkmedicareservices.com/bulletins/parta/general/2006/mpr06066.html> Remember; a complete and timely response to ADR requests may eliminate the need to submit appeals.

A. Overpayments and Demand Letters

If your appeal request is related to a Demand Letter issued as the result of a post-pay review, include a copy of the Demand Letter with your **signed** appeal request **in addition to the complete medical documentation to support the services**. Under the Limitation of Recoupment provisions, Medicare will not begin overpayment collection of debts (or will cease collections that have started) when a provider has requested a redetermination (first level of appeal) or a reconsideration by a Qualified Independent Contractor (QIC) (second level of appeal). See MM 6183 at <http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM6183.pdf> .

B. Documentation for Beneficiary Initiated Appeals

When a Medicare beneficiary requests a redetermination we are required to contact the provider to obtain the supporting evidence. It is important that you provide this

information promptly when you receive our request for the medical record. If an ABN or other advance notice was provided to the beneficiary, don't forget to include a copy along with the applicable medical record.

VII. Dismissals

A request for a redetermination may be dismissed under the following circumstances.

A. At the Request of the Party

A request for redetermination may be withdrawn at any time prior to the mailing of the redetermination upon the request of the party or parties filing the request for redetermination. You must submit the request in writing. A letter documenting your request to withdraw the appeal will be issued and will provide you with the criteria that must be met if you wish to review the service at another time.

B. Failure to File Timely

When a request for a redetermination is not filed within the required time limit (120 days from the date of the initial determination) and good cause for failure to file timely was not found, the request will be dismissed. It is the responsibility of the individual filing the request to provide information to support the late filing request.

Conditions and examples that may establish good cause for late filing by a provider may be found in the Claims Processing Manual, Chapter 29 Section 240.4 (<http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>)

C. Party Failed to Make a Valid Request

When it is determined that the provider failed to submit a valid request for redetermination as identified in **Section V**, the request will be dismissed. You may file your request again with the required information if it has been 120 days or less since the date of receipt of the initial determination.

D. Appeal Rights for Dismissals

You may request that we vacate our dismissal within **6 months** of the date of the mailing of the dismissal notice if you think you have good and sufficient reason to dispute the dismissal. You also have the right to appeal a dismissal to the QIC if you believe it was incorrect. The reconsideration request to the QIC must be filed within **60** days of the date of the dismissal. The dismissal letter will provide you with detailed information regarding your options and the time frames for each option.

VIII. Response to a Redetermination Request

Generally, a redetermination decision will be issued within 60 days of receipt of the redetermination request. For fully favorable decisions, the parties will receive notice of effectuation via a Medicare Summary Notice (MSN) or Remittance Advice (RA).

For partially favorable decisions and unfavorable decisions, the parties will receive a written redetermination decision with the rationale for the decision as well as notice of

effectuation via a MSN or RA, if applicable. If you do not agree with the decision, you will be provided instructions on how to pursue the next level of appeal, a reconsideration by the QIC. The decision will also include a Reconsideration Request Form that is to be submitted to the QIC if you wish to appeal the redetermination decision.

IX. Letter of Written Assurance

Prior to paying a provider for fully favorable or partially favorable **inpatient** cases where the beneficiary was previously liable, it must be ascertained whether the provider has been reimbursed for the previously denied services from another source. Medicare reimbursement will be withheld until the party has assured, in writing, that any prior payment has been refunded.

Returning a Letter of Assurance promptly will result in quicker payment to you. Only after the Letter of Assurance has been received will a claim adjustment be initiated to make payment. If no Letter of Assurance is received, no payment will be made.

X. CERT Appeals vs. Claim Adjustments

Some Part A providers are cancelling claims and resubmitting adjusted claims when CERT alerts them via a Tech Stop or Non-Response Contact that documentation is missing or that a coding error has occurred. Because these claims have been medically reviewed by the CERT contractor, providers are instructed to cease the practice of cancelling and adjusting claims that are selected in the CERT review process.

At the time of the Tech Stop or Non-Response Contact, the claim has been medically reviewed, but has not yet been denied. Highmark Medicare Services will initiate the adjustments for any necessary denials. When the CERT adjustment has been made in the FISS system, it will appear as an XXH type of bill. If you need to make a correction or addition to the claim, providers may appeal the denials on the XXH type of bill. The proper appeals process should be followed.

Providers should continue the practice of submitting an adjustment claim for an incorrectly billed line item, when the provider identifies the error outside of the medical review or CERT process.

XI. Addresses for Redeterminations and Clerical Error Reopenings

Pennsylvania Part A: For Part A Pennsylvania providers send redetermination and clerical error reopening requests to the following address:

Highmark Medicare Services
Attn: Part A Appeals Department
P.O. Box 890385
Camp Hill, PA 17089-0385

Maryland/District of Columbia Part A: For Part A Maryland and the District of Columbia providers send redetermination and clerical error reopening requests to the following address:

Highmark Medicare Services
Attn: Part A Appeals Department
P.O. Box 890386
Camp Hill, PA 17089-0386

New Jersey Part A: For Part A New Jersey providers send redetermination and clerical error reopening requests to the following address:

Highmark Medicare Services
Attn: Part A Appeals Department
P.O. Box 890420
Camp Hill, PA 17089-0420

Delaware Part A: For Part A Delaware providers send redetermination and clerical error reopening requests to the following address:

Highmark Medicare Services
Attn: Part A Appeals Department
P.O. Box 890417
Camp Hill, PA 17089-0417

XII. References

The Medicare Claims Processing Manual, Chapter 29, "Appeals of Claims Decisions"
<http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>

MLN 4147 – "Reopenings and Revisions of Claim Determinations and Decisions"
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4147.pdf>

Change Request 5554 - Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) and the ALJ Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands
<http://www.cms.hhs.gov/Transmittals/Downloads/R1229CP.pdf>

Clerical Error reopening Form
<http://www.highmarkmedicareservices.com/parta/forms/medicare-reopening-request-form.pdf>

Redetermination Request Form
<http://www.highmarkmedicareservices.com/parta/forms/med-a-redetermination-request-form.pdf>

Medicare Reconsideration Request Form – CMS 20033
<http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>

Brochure - Appeals Process
<http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf>

Change Request **6315** – **January 2009** Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2
<http://www.cms.hhs.gov/Transmittals>

Interactive Voice Response (IVR) Unit - This is used for general claim information and claim status. Call **1-877-235-8048**. Please see the **IVR Quick Reference Guides** at <http://www.highmarkmedicareservices.com/parta/index-quick-ref.html>