Session #: W16

Successfully Managing the Medicare Review Process: ADRs, RACs, CERTs, ZPICs

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Objectives:

• List 4 Medicare entities that may require a documentation review.
• Identify which Medicare entity that is mainly concerned with the identification of fraudulent practices.
• Verbalize the required timeframe for responding to the Medicare reviewer with necessary documentation.
• State two (2) strategies for meeting the signature requirements for Medicare review purposes when the therapist’s signature is illegible.
• Identify where to find the guidelines related to appealing the initial determination.
OIG report

- 25% of SNF claims incorrectly billed—most upcoded to Rehab Ultra High inappropriately.
- 47% of claims had MDS errors in RUG items.
- Recommendations:
  1. increase and expand reviews of SNF claims,
  2. use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs,
  3. monitor compliance with new therapy assessments,
  4. change the current method for determining how much therapy is needed to ensure appropriate payments,
  5. improve the accuracy of MDS items, and
  6. follow up on the SNFs that billed in error.
- CMS concurred with all six recommendations.

Medicare Reviewers

1. Fiscal Intermediary/Medicare Administrative Contractors (FI/MAC)
2. Recovery Audit Program (RAC)
3. Comprehensive Error Rate Testing (CERT)
4. Zone Program Integrity Contractor including Program Safeguard Contractors (ZPIC/PSC)
5. Office of Inspector General (OIG)
6. Quality Improvement Organization (QIO)
7. UPIC (proposed)
8. SMRC (StrategicHealthSolutions LLC)

FI/MAC

- The Medicare Administrative Contractors (MACs) shall analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant.
- The goal of MAC administrative actions is to correct the behavior in need of change and prevent future inappropriate billing.
- The priority for MACs is to minimize potential future losses to the Medicare Trust Funds through targeted claims review while using resources efficiently and treating providers and beneficiaries fairly.
FI/MAC Reviews

- ADRs (Additional Documentation Request)
  - Usually a claim or a few claims per provider
- Probes
  - MACs have the discretion to select target areas because of:
    - High Volume of services;
    - High cost
    - Dramatic change in frequency of use;
    - High risk problem-prone areas; and/or
    - RAC, OIG or GAO data demonstration vulnerability. (Probe reviews are not required when targeted areas are based on data from these entities).

Prepayment/Postpayment

- Prepayment reviews include claims that have been submitted to the FI/MAC but will not be paid until the review has been completed and a determination has been made. This type of review always results in an "initial determination."
- Postpayment reviews may occur for claims that have been paid within the last few years. This type of review results in no change to the initial determination or a "revised determination" indicating an overpayment or underpayment has occurred.

ADR Notification

- DDE screen for prepayment reviews.
- Provider letter for postpayment reviews.
Use DDE to check for ADRs

DDE Screen

Provider-Specific Review

- When MAC data analysis indicates that a provider-specific potential error exists that cannot be confirmed without requesting and reviewing documentation associated with the claim, the MAC shall review a sample of representative claims, usually 20-40 claims.

- Provider Notification: MAC shall notify providers in writing that a probe sample is being conducted.
Recovery Audit Programs

- Recovery Auditor previously known as Recovery Audit Contractors (RACs)
- Function:
  - Review Medicare Fee-For-Service claims on a post-payment basis to determine if improper underpayments or overpayments were made on claims; and
  - Review medical records to make an appropriate determination, as needed.

Recovery Audit Reviews

- Recovery Auditors will offer an opportunity for the provider to discuss the improper payment determination with the Recovery Auditors (this is outside the normal appeal process)
- Issues reviewed by the Recovery Auditor will be approved by the CMS prior to widespread review
- Approved issues will be posted to a Recovery Audits Website before widespread review
The Recovery Audit Review Process

Recovery Auditors review claims on a post-payment basis (Except for the 11 Pre-pay states for Part B)

Recovery Auditors use the same Medicare policies as Carriers, FIs and MACs: NCDs, LCDs and the CMS Manuals

Recovery Audits look back three years from the date the claim was paid

Recovery Auditors are required to employ a staff consisting of nurses, therapists, certified coders and a physician CMD

Three (3) Types of Review

- Automated (no medical record needed)
- Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
- Complex (medical record required)

Manual Medical Review

Outpatient claims began by the Recovery Auditors on April 1, 2013
Thresholds

- Importantly, there are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows:
  - one for occupational therapy (OT) services, and;
  - one for physical therapy (PT) and speech language pathology (SLP) services combined.
- Although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline.

RAC Reviews

- 11 States (including Ohio) will have Pre-payment reviews
- The other states will have immediate Post-payment review of claims over the $3700 threshold.

Improper payment

- If the Recovery Auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination.
- The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
All claims reviewed

- Typical Additional Documentation Requests (ADR) limits will not apply.
- All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the Recovery Auditors.

Timelines and notification

- The Recovery Auditors will conduct prepayment review within 10 business days of receiving the medical record.
- The ADR will be sent to the provider by the Medicare Administrative Contractor (MAC) with instructions to send the records to the Recovery Auditor.

Threshold applies to all settings:

- Private Practices
- Part B Skilled Nursing Facilities
- Home Health Agencies (TOB 34X)
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Outpatient Hospitals
Therapy cap website


CERT Review

- Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012
  - Requires the heads of Federal agencies, including the Department of Health and Human Services (HHS), to annually review programs it administers to improve agency efforts to reduce and recover improper payments

Requirements of IPERIA

- Identify programs that may be susceptible to significant improper payments
- Estimate the amount of improper payments in those programs
- Submit the estimates to Congress
- Report publicly the estimate and actions the Agency is taking to reduce improper payments
**Claim Selection**

- A stratified random sample is taken by claim type: Part A and Part B
- Claims are selected on a semi-monthly basis
- The final CERT sample is comprised of claims that were either paid or denied by the MACs

**Assignment of Improper Payment Categories**

- Improper Payment Categories
  - No Documentation
  - Insufficient Documentation
  - Medical Necessity
  - Incorrect Coding
  - Other

**ZPIC**

- The primary goal of the PSC and the ZPIC Benefit Integrity unit is to identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped.
- All cases of potential fraud are referred to the Office of Inspector General (OIG), Office of Investigations field office (OIFO) for consideration and initiation of criminal or civil prosecution, civil monetary penalty, or administrative sanction actions.
ZPIC Provider Notification

- The ZPIC shall notify selected providers prior to beginning a provider-specific review by sending an individual written notice.
- ZPICs shall indicate whether the review will occur on a prepayment or postpayment basis.
- This notification shall be mailed the same day that the edit request is forwarded to the MAC.

OIG

- The Office of Inspector General completes reports annually related to SNF PPS.
- Records are requested and reviewed to make their determinations and recommendations to CMS.
- Errors found in the record are reported to the Medicare Administrative Contractors (MACs) to recover the funds billed in error.

QIO Medicare Reviews

- Quality Improvement Organizations also complete Medicare reviews.
- Timeframes to submit documentation may be as little as 10 days.
Timeframes

• Documentation must be submitted within 30 calendar days of the request.
• MACs and ZPICs should not grant extensions to providers who need more time to comply with the request.
• Reviewers shall deny claims for which the requested documentation was not received by day 45.

Prepayment Review Time Frames

• Documentation must be submitted within 30 calendar days of the request.
• MACs and ZPICs should not grant extensions to providers who need more time to comply with the request.
• Reviewers shall deny claims for which the requested documentation was not received by day 45.

Postpayment Review Time Frames

• MAC, CERT and RAC shall notify providers that the requested documents are to be submitted within 45 calendar days of the request.
• ZPICs shall notify providers that requested documents are to be submitted within 30 calendar days of the request.
• MACs, CERT, and ZPICs have the discretion to grant extensions to providers who need more time to comply with the request.
• RACS shall follow the time requirements outlined in their Scope of Work.
Submission Methods

Medicare reviewers shall be clear in their ADR letters about what submission methods they will accept from a provider.

Acceptable Submission Methods

<table>
<thead>
<tr>
<th>MAC MR Units</th>
<th>CERT</th>
<th>RAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper</td>
<td>Shall give provider the option</td>
<td>Shall give provider the option</td>
</tr>
<tr>
<td>Fax</td>
<td>Have the discretion to give provider the option</td>
<td>Shall give provider the option</td>
</tr>
<tr>
<td>CD/DVD</td>
<td>Have the discretion to give provider the option</td>
<td>Shall give provider the option</td>
</tr>
</tbody>
</table>

Electronic Submission of Medical documentation (esMD)

<table>
<thead>
<tr>
<th>MAC MR Units</th>
<th>CERT</th>
<th>RAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have the discretion to give provider the option</td>
<td>Will have the discretion to give provider the option</td>
<td>Have the discretion to give provider the option</td>
</tr>
</tbody>
</table>

What will my FI accept?

- Check on your FI/MAC’s website for specific instructions.
- FI/MACs often have preferred forms to use.
Fiscal Intermediary/MAC

A/B MAC Current Jurisdictions

MAC Websites

- Cahaba: www.cahabagba.com
- CGS: www.cgsmedicare.com
- First Coast: www.fcsp.com
- National Government Services: www.ngsmedicare.com
- Noridian: www.nordianmedicare.com
- Novitas: www.novitas-solutions.com
- Palmetto: www.palmettogba.com
- WPS: www.wpsmedicare.com

Reimbursing Providers for Additional Documentation

- The MACs, CERT and ZPICs are not required to pay for medical documentation for either prepayment or postpayment review.
- The Recovery Auditors performing postpayment review of hospital inpatient prospective payment system (PPS) and long term care facilities are required to pay the providers for photocopying and submitting hard copy documents sent via mail. Recovery Auditors shall follow the payment rate methodology established in 42 CFR§476.78.
No Response

- If information is requested from both the billing provider or supplier and a third party and no response is received from either within 45 calendar days for MACs and Recovery Auditors or 30 calendar days for ZPICs after the date of the request (or within a reasonable time following an extension), the MACs, Recovery Auditors and ZPICs shall deny the claim, in full or in part, as not reasonable and necessary.

Request for Reopening the Claim

- You have the right to submit a request for a reopening. Reopening should be submitted to medical review with a cover letter indicating it is a reopening and must be received within 120 days from the remittance denial date.

Insufficient Response

- If the MAC, CERT, Recovery Auditor, or ZPIC requests additional documentation to verify compliance with a benefit category requirement, and the submitted documentation lacks evidence that the benefit category requirements were met, the reviewer shall issue a benefit category denial. If the submitted documentation includes defective information (the documentation does not support the physician’s certification), the reviewer shall deny the claim as not meeting the reasonable and necessary criteria.
Reopening Claims with Additional Information

- If the MACs and CERT receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim. MACs and CERT who choose to reopen shall notify the provider or supplier of their intent to reopen, make a MR determination on the lines previously denied due to failure to submit requested documentation, and do one of the following, within 60 calendar days of receiving the documentation in the mailroom:
  - Post-payment review—issue letter with revised denial reason
  - Pre-payment review—enter revised MR determination, new Medicare summary notice and remittance advise with new denial reasons
  - MACs and CERTs may choose not to reopen claims when documentation is received past the deadline

Documents Required

- ADR notification letter lists required documentation.

- Place a copy of the ADR notice as a face sheet/first page. On the face sheet, include the name of a contact at your facility who is available to answer questions and/or can provide documentation if it is needed.

Minimum Documentation Requirements

- Legible physician/clinician signatures and credentials for services provided. Signature logs and attestation statements should be submitted when physician and/or clinician signatures are illegible.
- Demand bill – Notice of Non-Coverage indicating Request for Medicare to Review
- Physician Certification form for Skilled Level of care
- Hospital Discharge Summary and Transfer Form
- Physician Orders, Physician Clinic/Progress Notes
- Nurse Notes
- Medication Administration Records
- Vital Sign Records, Weight Sheets, Care Plans, Treatment Records
- Documentation for the Look Back Period for each MDS billed – may be prior to the billing period
- Lab Reports/Results for the billing period
- PT/OT/SLP – Initial Evaluation, Plan of Care, Progress Reports, Treatment Encounter Notes, Discharge Summary, Therapy Minute Logs
- Quality Improvement Organization (QIO) Letter if applicable
- Itemization of Services
- Documentation that supports the medical necessity of the services provided
FAQ

• Do I need to send in documentation for SNF claims outside the from and through dates of the billing period if Medical Review requests documentation on a patient?
  - Yes, providers should include any orders that were obtained that pertain to the from and through dates of the claim along with all documentation for look-back periods supporting coding on the MDS which applies to this billing period. This may include but is not limited to treatment sheets, medication sheets, therapy notes, progress notes, and care plans.

FAQ

• Submit all the documentation that is requested on the Additional Documentation Request (ADR). The ADR documentation listed includes:
  • Legible physician/clinician signature and credentials
  • Initial evaluation and any re-evaluations
  • Plan of Care(s)
  • All progress reports since the initial evaluation
  • All physician signed certification/recertification since the initial evaluation
  • Physician orders
  • Treatment encounter note for each visit to support service billed
  • Discharge summary if applicable
  • Itemization of services
  • Notice of non-coverage if applicable
  • Records of patient's condition before, during and after this billing period to support the medical necessity and reason for the service. Note that this may extend to documentation for prior episodes of therapy services for the same condition

RAC Reviews for Part B Therapy Threshold

• Submit all the documentation that is requested on the Additional Documentation Request (ADR). The ADR documentation listed includes:

RAC Reviews for Part B Therapy Threshold

• Submit all the documentation that is requested on the Additional Documentation Request (ADR). The ADR documentation listed includes:
  • Legible physician/clinician signature and credentials
  • Initial evaluation and any re-evaluations
  • Plan of Care(s)
  • All progress reports since the initial evaluation
  • All physician signed certification/recertification since the initial evaluation
  • Physician orders
  • Treatment encounter note for each visit to support service billed
  • Discharge summary if applicable
  • Itemization of services
  • Notice of non-coverage if applicable
  • Records of patient's condition before, during and after this billing period to support the medical necessity and reason for the service. Note that this may extend to documentation for prior episodes of therapy services for the same condition

Keys to Success

• Submit your records in a timely manner.
• Present organized records.
• Include all requested documentation.
• Include additional information that will support your claim.
Review made easy

- Make your records easy to review.
- Obtain a copy of signed documents prior to submission.
- Some reviewers prefer a summary of the coverage but others do not. Know your FI/MAC’s preference.
- Place dividers between the sections (ADLS, Therapy, Nursing, Medications, Physician’s Orders, etc.)
- Place dividers between records (find samples on FI website)
- Copy records single sided (Don’t send originals)
- Do NOT highlight documents (blacks out documentation for the reviewer)
- Number pages before sending.
- Keep an exact copy of what was sent for the facility to reference
- If you are submitting records for more than one resident, clearly divide the records. Place a copy of the ADR request at the top of each selected claim.

Best Practices

- Have MDS Coordinator determine which MDS assessments affect the timeframe in question.
- Submit documentation to support each of the MDS assessments in addition to the documentation from the month in question.
- Obtain signature attestations for any illegible signatures. A signature log could suffice.
- Have Rehab Manager review the documentation to ensure that all necessary therapy information has been included.
- Team review the final product before making copies.

Submit Documentation in Timely Manner

- “Providers/suppliers who show a pattern of failing to comply with requests for additional supporting documentation for any claims submitted to CMS may be subject to complex medical review for all claims. This paragraph applies to both providers and suppliers and to instances in which CMS or its contractors request documentation directly from these entities to support services billed on the claim. This paragraph does not change or diminish the provider’s or supplier’s responsibility to provide required documentation.”
Signatures

A. Handwritten Signature:

- A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

Signature Log

B. Signature Log:

- Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document.

- Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created.

- Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

Sample Signature Log

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Credential</th>
<th>Signature</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Sample Attestation

• "I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Signature ________________________ Date________

Attestation limitations

• Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.

Electronic Signatures

• Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws.

• The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.
Signature Stamps Prohibited

- "Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

- **EXCEPTION 4:** CMS would permit 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. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

Illegible or Missing Signature

- If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated.

Missing Signature FAQ

- **Question:** What do I do if I haven't signed an order or documentation?

  - **Answer:** Providers should not add late signatures to the medical record, other than the short delay that occurs during the transcription process. Providers should utilize the signature authentication process. Medicare does not accept retrospective orders.
Dated Signatures

**Question:** Do my signatures need to be dated?

**Answer:** To be in compliance with conditions of participation and receive accreditation, all signatures need to be dated and timed. However, Medical Review (MR) needs to be able to determine on which date the service was performed or ordered. If the entry immediately above or below the entry is dated, MR may reasonably assume the date of the entry in question. Specific signature requirements found in NCDs, LCDs or other CMS manuals supersede the instructions in CR 6698.

Provider Error Rate Formula

- The MACs shall use the following formula for prepayment review to calculate the provider’s service specific error rate:
  - Dollar amount of allowable** charges for services billed in error as determined by MR***
  - Dollar amount of allowable** charges for services medically reviewed

- For postpayment review, use the following formula to calculate the provider’s service specific error rate:
  - Dollar amount of services paid in error as determined by MR***
  - Dollar amount of services medically reviewed

Vignettes

- The following vignettes provide guidance on how the MACs shall characterize and respond to varying levels of confirmed errors. These are examples of results from medical review accompanied by suggested corrective actions.
Vignette #1

- Twenty claims from one provider are reviewed. Once claim is denied because a physician signature is lacking on the plan of care. The denial reflects 7 percent of the dollar amount of claims reviewed. Judicious assessment of medical review resources indicates no further review is necessary at this time. The MAC uses data analysis to determine where to target medical review activities in the future.

Vignette #2

- Forty claims from one provider are reviewed. Twenty claims are for services determined to be not reasonable and necessary. These denials reflect 50 percent of the dollar amount of claims reviewed.

- One hundred percent prepayment review is initiated due to the high number of claims denied and the high dollar amount denied. The MAC provides notification to the provider about specific errors made and makes a priority referral to POE to inform them of the severity of the problem.

Vignette #3

- Forty claims from one provider are reviewed. Thirty-five claims are denied. These denials reflect 70 percent of the dollar amount of claims reviewed. Payment suspension is initiated due to the high denial percentage and the Medicare dollars at risk. The MAC provides notification to the provider about the specific errors made and makes a priority referral to POE to inform them of the severity of the problem.
Vignette #4

- Forty claims from one provider are reviewed. Thirty-three claims are denied. These denials reflect 25 percent of the dollar amount of the claims reviewed. The MAC provides notification to the provider about the specific errors made. The MAC initiates a moderate amount (e.g., 30 percent) of prepayment medical review to ensure proper billing.

Result Notification Timelines

- Prepayment: MACs shall do the following within 60 calendar days of receiving the requested documentation:
  1. Make and document the review determination, and
  2. Enter the decision into the Fiscal Intermediary shared System (FISS), Multi-Carrier system (MCS), or the VIPS Medicare System (VMS).

Result Notification Timelines

- Postpayment Reviews:
  - The MAC or Recovery Auditor shall make a review determination, and mail the review results notification letter to the provider within 60 calendar days of receiving the requested documentation, provided the documentation is received within 45 calendar days of the date of the ADR.
  - The MAC has the option to either:
    - Begin counting the 60 days at the receipt of each medical record in the mailroom. Each new medical record would have an independent 60 day time period associated with it; or
    - Wait until all requested medical documentation is received in the mailroom. The date on which the last of the requested medical documentation is received would represent the beginning of the 60 day time period.
Result Notification Timelines

- **ZPIC:**
  - For claims associated with any referrals to ZPIC for BI investigations, MACs shall stop counting the 60-day time period on the date the referral is made. The 60-day time period will be restarted on the date the MAC receives requested input from the ZPIC or is notified by the ZPIC that the referral has been declined.

### Appealing Negative Decisions

<table>
<thead>
<tr>
<th>Appeal</th>
<th>Time Limit</th>
<th>Minimum Amount in Controversy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redetermination (initial appeal)</td>
<td>120 days from the date of the initial claim determination notice</td>
<td>None</td>
<td>You must file a Redetermination Request before filing a Reconsideration Request with the QIC.</td>
</tr>
<tr>
<td>Reconsideration (initial appeal)</td>
<td>180 days from the date of the initial claim determination notice</td>
<td>None</td>
<td>Request should be mailed directly to the QIC. The address for the QIC is included in the redetermination letter with your reconsideration request.</td>
</tr>
</tbody>
</table>
### Appeals Time Limit Minimum Amount in Controversy Notes

<table>
<thead>
<tr>
<th>Appeals</th>
<th>Time Limit</th>
<th>Minimum Amount in Controversy</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Law Judge (ALJ)</td>
<td>60 days from receipt of the QIC decision</td>
<td>$140 must remain in controversy</td>
<td>The QIC decision letter will provide the HHS OIGMA office to which an ALJ request is mailed.</td>
</tr>
<tr>
<td>Departmental Appeals Board Review (DAB)/Appeals Council</td>
<td>60 days from the date of the ALJ decision or dismissal</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Federal District Court Review</td>
<td>60 days from the date of the Appeals Council decision</td>
<td>$1400 for request files on or after 1/1/13</td>
<td></td>
</tr>
</tbody>
</table>

### Appeal process

- Follow directions on the on the remittance advice (RA) or Medicare Summary Notice (MSN) to request a redetermination.
- Complete the Medicare Redetermination Request form (CMS-20027) found on your MAC’s website.
- Complete a letter summarizing the resident’s illness/injury, hospitalization, admission to the SNF, Medicare skilled services and care provided. Tell the resident’s story.
- Submit all requested documentation and any additional information that will support your claim.
- Be timely.

### Cannot appeal

- Claims rejected as unprocessable (billing errors, indicated with remark code MA130) have no appeal rights and should not be submitted as redetermination requests. The only way these can be considered is for the claim to be corrected and resubmitted.
Appeals for Multiple Claims Involving the Same Issue

If multiple claims involve the same issue, it is not necessary to submit each appeal separately. A single appeal can be filed for multiple claims. If multiple claims involve the same issue, one appeal request can be submitted with all claims included. All appeal requests must be submitted in writing. Each claim in a multiple request must be clearly identified in some manner to allow identification of:

• The beneficiary
• The Medicare Health Insurance Claim (HIC) number
• The specific service or item for which the redetermination is being requested (copies of the Remittance Advice or a spreadsheet are acceptable)
• The specific dates of service

Outcome Notification

• The Medicare reviewer will notify the provider of the determination.
• If payment must be adjusted, the letter will instruct the provider how to proceed.
• The notification will instruct the provider of the address for the next level of appeal, if applicable.

Resources

• Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and Taking Corrective Actions
• Medicare Program Integrity Manual Chapter 6 - Intermediary MR Guidelines for Specific Services
• MLN Matters® Number: MM6698
• MLN Matters Number: SE0420
• MLN Matters ICN 908524 January 2013
• MLN Matters ICN006562 January 2013
Questions?

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