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How to Appeal a Claim Determination

The Medicare program offers to physicians, suppliers, and beneficiaries the right to appeal claim determinations made by the carrier. The purpose of the appeals process is to ensure the correct adjudication of claims. The appeals activities conducted by carriers are governed by instructions from the Centers for Medicare & Medicaid Services (CMS).

Part B providers and beneficiaries have 120 days to file a request for a redetermination from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). This is the first level of appeal conducted by Medicare contractors.

Medicare law provides five possible levels of appeal as explained in the chart. The chart shows the various levels along with the corresponding time limit and dollar amounts involved. The chart can be a helpful tool in your office.

Time and Monetary Limits of the Appeals Process

Level/Type	Time Limit	Amount in Controversy Required (after deductible & co-insurance)
Redetermination	Within 120 days of receipt of the notice of initial determination	No minimum
Qualified Independent Contractor (QIC) Reconsideration	Within 180 days from the date of receipt of the notice of the redetermination	No minimum
Administrative Law Judge Hearing (ALJ)	Within 60 days after the receipt of the reconsideration notice	*For requests filed on or after January 1, 2009, at least \$120 remains in controversy.
Departmental Appeals Board (DAB)	Within 60 days from the date of receipt of the ALJ decision	No minimum
Judicial Review (Federal Court)	Within 60 days of the date of the DAB's decision	* For requests filed on or after January 1, 2009, at least \$1,220 remains in controversy.

* Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

Who May Submit An Appeal Request?

- Providers, as defined in 42 CFR 400.202, with appeal rights as specified in regulation at 42 CFR 405.710(b).

- Suppliers (including physicians, as defined in 42 CFR 400.202) with appeal rights as specified in regulations at 405.801(b), accepting assignment on the claim at issue, and suppliers with refund requirements under §1842(l)(1), 1834(a)(18), or 1834(j)(4) of the Act.
- Beneficiaries and their authorized representatives.

The provider/supplier may appeal services for which assignment was accepted. The beneficiary or their representative may request an appeal on any service processed for them. If the beneficiary signs an authorization statement, the provider may act as the beneficiary's representative on an unassigned claim. Form 1696-U4 properly signed and executed will serve this purpose. (This form may be obtained by contacting the Social Security Office.) Any decision and/or payment will be sent to the authorized representative in this instance. For an unassigned claim, the provider/supplier may request a redetermination if Medicare B denies the service as not reasonable and necessary or the provider has billed in excess of the Limiting Charge and the provider/supplier is required to refund any fees collected from the beneficiary.

How to Submit a Part B Redetermination

The Medicare program offers to physicians, suppliers, and beneficiaries the right to appeal claim determinations made by the carrier. The purpose of the appeals process is to ensure the correct adjudication of claims. The appeals activities conducted by carriers are governed by instructions from CMS.

Medicare Part B providers have 120 days from the receipt of the Remittance Notice to file a request for a redetermination, the first level of appeal conducted by Medicare contractors. Part B Beneficiaries have 120 days from the receipt of the Medicare Summary Notice to file a request for a redetermination.

When the provider or beneficiary disputes a carrier's determination, a redetermination may be requested. This must be done in writing to the address below.

When a claim was originally denied for lack of information (unprocessable), a new claim should be submitted with additional information. A redetermination cannot be performed. If the provider is unsure of what additional information is needed, check all remark codes on the Provider Remittance Notice.

Written Redetermination

A redetermination may be requested by writing to:

Wisconsin	Illinois
WPS Medicare Part B Wisconsin Redetermination P.O. Box 1268 Madison, WI 53701	WPS Medicare Part B Illinois Redetermination P.O. Box 4433 Marion, IL 62959
Michigan	Minnesota
WPS Medicare Part B Michigan Redetermination P.O. Box 5533 Marion, IL 62959	WPS Medicare Part B Minnesota Redetermination 8120 Penn Ave South, Suite 200 Bloomington, MN 55431-1394

Providers and beneficiaries can use a CMS-20027, Medicare Redetermination Request form to express disagreement with the initial claim determination. The CMS-20027 form can be obtained on the CMS Website at <http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf>.

If the claimant chooses not to use the form, the request can best be handled without further delay if the following information is included in the letter:

- Beneficiary name,
- Medicare Health Insurance Claim Number (HICN),
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form,
- Which item(s), if any, and/or service(s) are at issue in the appeal,
- Name and a signature of the party or representative of the party.

Development of Requests for Provider/Supplier-Initiated Appeals

If additional documentation is needed to process an appeal, the party submitting the appeal (i.e., the provider/supplier) should obtain and submit the documentation within the prescribed time period following notification of an initial determination.

Providers/suppliers, Medicaid State agencies or the party authorized to act on behalf of the Medicaid State agency are responsible for submitting documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies. This documentation may be supplied with the appeal request or at the request of the contractor. Failure to submit requested documentation in a timely manner may result in processing delays.

Appeals and the Medicare Summary Notice and Provider Remittance Notice

The Medicare Summary Notice (MSN) and Provider Remittance Notice (PRN) specify the date by which a beneficiary, provider, or supplier must file an appeal of a denied claim to the contractor. WPS has made the necessary system changes so that the date by which a reconsideration or redetermination must be filed with a contractor will be automatically calculated and listed on the Medicare Summary Notice (MSN).

Reconsideration (Second Level of Appeal)

If you received a redetermination and you are dissatisfied with the decision, the next level is a reconsideration with the Qualified Independent Contractors (QIC). There is no minimum dollar amount required for requesting a reconsideration. In addition, the request for reconsideration must be filed within 180 days of the date of receipt of the notice of redetermination. Finally, requests must be submitted on CMS Form 20033 and can be obtained from the CMS Website at <http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>.

You would then mail your request to the QIC at the below address:

First Coast Service Options, Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208