Appeals

1. What information is required for submitting an appeal request?

The first level of appeal is a redetermination. Please use the Medicare Part A [redetermination and clerical error reopening form](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName%3A00004472) when requesting a redetermination.

Your request for a redetermination must be submitted, in writing or via Novitasphere ([JH](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH)) ([JL](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JL)), and filed within 120 days from the date on your remittance advice or the beneficiary's Medicare summary notice and it must include:

* The beneficiary name.
* The Medicare Beneficiary ID number.
* The specific service(s) and / or item(s) for which the redetermination is being requested.
* The specific date(s) of service; and
* The requestor’s relationship to the provider.

Your appeal request may be dismissed if any of the above information is not included with the request.

1. What documentation should be submitted with the redetermination request?

Submit all evidence that supports coverage of the service(s) being appealed. If the denial of the items / services resulted from the failure to respond timely to an additional documentation request (ADR), include all the information requested in the ADR with the appeal request. Please do not submit the ADR request letter with the redetermination as this can impact the appeal submission.

1. What is a clerical error reopening?

A clerical error reopening (CER) is used to correct a clerical error that resulted in the incorrect processing of the claim, even though the claim processed correctly at the time of submission based on current evidence. A CER should be filed within one year from the initial determination of the claim except for reporting an overpayment.

CMS established a process, separate from appeals, whereby providers could correct minor errors or omissions. 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.
* Incorrect data items, such as provider number, use of a modifier or date of services.

Requesting a reopening does not delay the timeframe to request an appeal.

To expedite your clerical error reopening requests, please use the Medicare Part [redetermination and clerical error reopening form](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName%3A00004472).

When requesting a clerical error reopening, please be sure to give a clear and accurate description of what is to be changed on the claim and send in a corrected UB-04 claim form.

Note: The clerical error reopening process does not replace the submission of an adjustment or corrected claim via direct data entry in the Fiscal Intermediary Standard System.

1. I submitted a redetermination to Novitas, which was not accepted, and received a letter back stating I didn't pass privacy. Why would I receive a letter that I have not passed privacy when I met all the privacy requirements for an appeal?

A general inquiry is a written correspondence initiated by you that includes questions related to Medicare billing, processing, or payments. There may be times when a redetermination cannot be accepted, and the request will be forwarded to the general inquires department for a response to you. We will send you a letter explaining why the appeal was not accepted. At this point, if applicable, you can file a new redetermination if it's within the 120-day timeframe.

If a redetermination is not accepted and sent to general inquires it must meet privacy requirements or it may not process. The privacy requirements include:

Provider information:

* Provider name
* Provider address
* PTAN
* NPI
* Last five digits of Tax ID

Patient demographics:

* Name
* Medicare number
* Date of birth (this is not required on a redetermination request form)
* Date of service
1. How can I find the status of my redetermination request?

To verify the status of your redetermination request, you may use the appeals inquiry status tool or Novitasphere ([JH](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH))([JL](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JL))

1. Can I appeal a claim that denied because it was submitted to Medicare untimely?

Denials for untimely filing are not appealable unless one of the exception situations described in the CMS [Publication 100-04, Claims Processing Manual, Chapter 1, §70.7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf) applies to the claim in question.

1. Can I appeal a claim if it processed with a Medically Unlikely Edit (MUE) denial?

MUE denials do have appeal rights, but because many MUE denials are the result of incorrect billing, we suggest you review your claim data to make sure it was correctly coded for the service and units rendered. Please ensure you are sending medical records to support your redetermination request.

1. Can I appeal a rejected claim?

No. You should correct rejected claims through the normal claim submission / adjustment process.

1. Does the provider receive a copy of the appeal decision when an appointed representative requests an appeal?

No, providers will not receive a copy of the appeal decision when requested by an appointed representative.

Reference

CMS [Publication 100-04, Claims Processing Manual, Chapter 29, §270.1.4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf)

1. Can we appeal all claim determinations?

No, not all claim determinations are appealable. To determine if a claim is appealable, locate the claim-specific group reason codes, such as claim adjustment reason code (CARC) and remittance advice remark code (RARC) on the electronic remittance advice (ERA) or standard paper remittance (SPR). Use the codes in conjunction with the glossary section of the ERA / SPR to explain the outcome of the claim.

Note: The Washington Publishing Company maintains the CARCs and RARCs. Visit the [Washington Publishing Company](https://x12.org/codes) to view or print these codes.

1. When we file a redetermination for an overpayment is recoupment stopped?

You may stop recoupment at two points:

* When a valid and timely request for a redetermination (i.e., within 30 days from the date of the overpayment letter) is received. Recoupment stops or is delayed pending results of the appeal.
* When receipt of an unfavorable or partially favorable redetermination decision and there is notification that the qualified independent contractor received a valid and timely request for reconsideration within 60 days of the redetermination.

Note: Interest continues to accrue even when recoupment stops.

1. When should supporting documentation, for services rendered, be submitted with the appeal request?

For us to consider all the facts supporting your case, it is in your best interest to submit the appropriate supporting documentation for the patient's claim(s) in question. If you do not submit supporting documentation, we will conduct the redetermination using information in our possession.

Please make sure all copies of documentation include the patient's name and are complete, legible, with an electronic or hand-written physician's / non-physician practitioner's signature, and contain both sides of each page, including page edges.

Complete copies should include specific records to support the services on the claim(s) you are appealing and, as applicable, the following:

* Physician progress notes
* Physician orders
* Nurses' notes
* Medication records
* Graphic reports
* Operative reports
* Pathology reports
* Consultant notes
* All lab reports
* Diagnostic test results (regardless of where they are performed)
* History and physical notes
* Hospice records
* Home health progress notes
* Certificate of medical necessity
* Skilled nursing facility records
* Ambulance records, physician certification statement (for non-emergent transports)
* Emergency room records
* Advance beneficiary notice
1. How long does it take to get a response to my appeal/redetermination?

Generally, a redetermination decision will be issued within 60 days of receipt of your redetermination request. This time may be longer if we need to obtain additional documentation to complete our review.

For fully favorable decisions, you will receive notice via your remittance advice.

For partially favorable decisions and unfavorable decisions, you will receive a written redetermination decision with the rationale for the decision as well as notice via your remittance advice.

1. What option do I have if I have multiple claims that need a CER for the same error?

You may use the [redetermination and clerical error reopening form](https://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName%3A00004472), with an attached excel or word document. Please ensure that all required elements from the request form are listed on the attached document.

* Patient privacy details:
* Beneficiary name
* Beneficiary Medicare number
* Claim number(s)
* Date(s) of service
* Procedure code(s) in question
* Reason for request:
* Can be listed in the narrative field on the CER
1. Where do I send a request for reconsideration?

Reconsideration is the second level of appeal. If you do not agree with the outcome of a redetermination, you may request a reconsideration with the qualified independent contractor. You can send a reconsideration request via:

* [C2C Innovative Solutions, Inc. Appeal Portal](https://www.c2cinc.com/Appellant-Signup)
* Fax C2C: 904-539-4074
* Novitasphere Portal ([JH](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH)) ([JL](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JL))

C2C Innovative Solutions, Inc
QIC Part A East
PO Box 45305
Jacksonville FL 32232-5305.

Please refer to our Tutorial: How to complete the Medicare reconsideration request form (CMS-20033) for instructions and mailing information.

1. What options do I have to submit a redetermination request?

There are three options to submit a redetermination request:

* Fax 888-541-3829
* Mail (JH)(JL)
* Novitasphere ([JH](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JH))([JL](https://www.novitas-solutions.com/webcenter/portal/Novitasphere_JL))
1. What actions do I need to take if I receive a favorable appeal decision from a higher level of appeal (e.g., administrative law judge)?

If you receive a favorable appeal decision beyond the first level of appeal (redetermination), the contractor that determined the appeal was favorable, will notify us to reprocess your claim for payment.

