Is a Medicare Appeal Worthwhile?

By Elizabeth Woodcock, MBA, FACMPE, CPC

If you are dissatisfied with a denial of payment by your Medicare contractor, you can appeal the decision. The Centers for Medicare & Medicaid Services (CMS) recently announced attempts to streamline the process by no longer requiring signatures, thus enabling documents to be submitted in a more efficient, streamlined manner. The appeals process continues to feature five levels of appeal, each of which have a deadline. To initiate the first level entitled “Redetermination,” for example, you need to file the appeal within 120 days after receiving the remittance.

Many practices report success related to having denials overturned. For those practices that are still stuck in the appeals process, the third level of appeals is managed by the Medicare Office of Hearing and Appeals. It is so backlogged – the turnaround time in 2018 was a remarkable 1,321 days - that CMS opened a low-volume appeals initiative last year. This featured payment of 62% of billed charges for appeals less than $9,000, just to get them out of the queue. A federal judge recently issued a warning to CMS to reduce the backlog by 2020, so many are projecting another payout soon.

Although the process isn’t easy, if you feel that your claims were not paid fairly, appealing a Medicare claim is possible. For simple, step-by-step instructions, see Medicare’s guide to submitting an appeal.

For more information about the May 2019 changes to the appeals process, visit the Rules and Regulations page here.

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