Denials Management & Appeals Reference Guide

A comprehensive resource to maximize your revenue and streamline your appeals process

FIRST EDITION
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This publication provides situational examples and explanations, of which many are taken from the Medicare perspective. The individual, however, should understand that while private payers typically take their lead regarding reimbursement rates from Medicare, it is not the only set of rules to follow.

While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

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## Contents

Introduction ......................................................................................................................... 1

### Chapter 1
**Denials Management** .................................................................................................. 3
- Tips for preventing denials .................................................................................................... 3
- Explanation of Benefits (EOB) and Remittance Advice (RA) .................................................. 5
- Cut Down on Denials With This Handy Primer ...................................................................... 5

### Chapter 2
**Denials** ............................................................................................................................ 11
- Working a Denial ................................................................................................................ 11
- Common Denials ................................................................................................................ 12
  - Demographic Denials ....................................................................................................... 12
  - Coding Denials ................................................................................................................. 13
- Benefit Denials .................................................................................................................. 17
- Back-End Billing Denials .................................................................................................... 19

### Chapter 3
**National Correct Coding Initiative (NCCI)** ..................................................................... 21
- Modifiers and NCCI Edits .................................................................................................... 24
  - Modifier 25 .................................................................................................................... 24
  - Modifier 58 .................................................................................................................... 25
  - Modifier 59 .................................................................................................................... 25
- Medicaid and NCCI ........................................................................................................... 26
- Medically Unlikely Edits (MUEs) ..................................................................................... 27

### Chapter 4
**The Global Surgical Package** ......................................................................................... 33
- Global Package as Defined by CPT® .................................................................................. 33
- Global Package — Non-Medicare Health Plans ................................................................ 33
- Surgery as Defined by Medicare ........................................................................................ 33
  - Status Indicators ............................................................................................................. 33
- Services Included in the Global Package ........................................................................... 34
- Services Not Included in the Global Package ................................................................... 34
- Maternity Care and Delivery Global Package ................................................................... 35
- Modifiers Used to Report Payable Services within the Global Package .......................... 36
Chapter 5
Medical Policies ................................................................. 41
National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) ................. 41

Chapter 6
Appeals .................................................................................. 47
Use these tips when appealing a denial: ........................................... 47
Medicare Appeals Process ........................................................ 48
Level 1 - Redetermination ......................................................... 49
Level 2 - Reconsideration ......................................................... 49
Level 3 - Administrative Law Judge ........................................... 50
Level 4 - Appeals Council ....................................................... 50
Level 5 - Judicial Review ....................................................... 51
Unitedhealthcare Appeals Process ............................................. 51

Chapter 7
Documentation and the Medical Record ........................................ 53
Medical Record Entries .......................................................... 54
Medical Record Retention Requirements .................................... 54
Basic Medical Record Documentation ....................................... 54
Types of Documentation ......................................................... 55
Date and Time .......................................................................... 56
Signatures .............................................................................. 56
Medical Record Requests ....................................................... 57
Minimum Necessary ............................................................. 57

Chapter 8
Incident-to Guidelines and Shared Visits ....................................... 59
Incident-to Guidelines ............................................................. 59
Split/Shared Services .............................................................. 59
Split/Shared Services vs. Incident to Billing Services ..................... 59
Modifiers and Reciprocal Billing ............................................... 60
Know These Substitute Provider (Locum Tenens) Basics .................. 61
Take Care with Modifiers ....................................................... 62

Chapter 9
Evaluation and Management Denials .......................................... 65
Know Your Payer’s Rules ........................................................ 72
Use Elements When Time Is Unknown ....................................... 72
Chapter 10
Modifiers........................................................................................................................................73
  Modifier 22................................................................................................................................73
  Modifier 24................................................................................................................................74
  Modifier 25................................................................................................................................74
  Modifier 26................................................................................................................................75
  Modifier 50................................................................................................................................75
  Modifier 51................................................................................................................................76
  Modifier 52................................................................................................................................76
  Modifier 53................................................................................................................................77
  Modifiers 54, 55, and 56................................................................................................................77
  Modifier 57................................................................................................................................78
  Modifier 58................................................................................................................................78
  Modifier 59................................................................................................................................79
  Modifier 79................................................................................................................................79
  Modifier 80................................................................................................................................80

Chapter 11
ICD-10-CM Coding...........................................................................................................................87
  Background................................................................................................................................87
  Medical Necessity..........................................................................................................................88
  Overview of ICD-10-CM Layout....................................................................................................88
    Tabular List.................................................................................................................................88
    Index to Diseases and Injuries.....................................................................................................89
    Conventions...............................................................................................................................89
    Other Conventions......................................................................................................................90
  Steps to Look Up a Diagnosis Code............................................................................................92

Resources........................................................................................................................................95
  1. Denials Tracking Worksheet......................................................................................................95
  2. Medicare Redetermination Request Form – 1st Level of Appeal........................................96
  3. Medicare Reconsideration Request Form – 2nd Level of Appeal.........................................97
  4. Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal Form..........98
  6. Appeal Letter Template...........................................................................................................102
     Chapter 15 - Covered Medical and Other Health Services....................................................102
  8. Code of Federal Regulations, Internal claims and appeals and external review processes...108
Now's the time to get the upper hand on denials and appeals!

**Denials Management & Appeals Medical Reference Guide** equips you to fend off denials, collect the revenue your practice deserves, and climb out of the appeals abyss once and for all.

Map out a plan for pre-claim review, optimize your revenue with face-to-face documentation tips, learn when you can “reopen” a claim to fix an error, wield proven strategies for appeals that win your earned income, and much more.

We’ve compiled expert tips and handy references in this guide, designed to become a vital resource full of critical tips and tools you’ll rely on day after day. Plus enjoy bonus features including user-friendly guidance and proven strategies, and a quick reference to regulations you need to succeed.

With **Denials Management & Appeals Medical Reference Guide**, you’ll conquer correct prior authorizations, learn tips for improving documentation to avoid denials, nail down how to respond to overpayment demands, and get a leg up on correct coding and billing.

Put an end to rework and revenue loss. Denial mayhem can be defeated with the **Denials Management & Appeals Medical Reference Guide**.
CHAPTER 1

Denials Management

When payers adjudicate (evaluate and determine) a claim, it results in payment or denial notification. When a claim is denied, the billing staff should attempt to resolve the denial by:

- Providing additional information if required by the payer to complete payment processing;
- Appealing the denial with the payer; or
- Seeking payment from the patient.

Medical group collections staff are continually challenged by the low-dollar, high-volume nature of the physician revenue stream. Like claim errors, denials will delay the payment process and decrease the effectiveness of the revenue cycle. Keeping denial rates low will reduce the money in accounts receivable (A/R).

Spending time on the phone resolving claim denials is inefficient and is cost effective only for high dollar accounts. The denial notification from the payer will typically indicate the reason for the denial and the next action that is required for claim resolution and payment. This information should be tracked and used to respond to the payer with the requested information. Efficiencies can be found in batching these responses, whenever possible.

A common failure is the lack of effective denials management. Maintaining good control of denials management is best accomplished by regularly reviewing the denial reason codes to determine why the claim was denied and making corrections to prevent similar denials in the future. Run and review a denial reason report, at least monthly. Upon identifying the reasons for the denial, make efforts to review current office processes and eliminate errors that led to the denial. Per MGMA, the six fundamentals to prevent denials are:

1. Educate and communicate
2. Verify Insurance prior to service
3. Know your payers
4. Document appropriately
5. Take advantage of technology
6. Monitor, analyze, revise

By closely monitoring denials, you can determine errors made by staff and by insurance companies. Running the denial report by payer and denial reason code, will quickly identify patterns of errors or common denials by payer. One of the most financially responsible ways to decrease days in A/R is to implement an improvement effort for denials management processes.

Tips for preventing denials

1. Use the 80/20 rule: As a rule of thumb 80 percent of issues are caused by 20 percent of the problems.
2. Determine actions needed to correct identified problems.
3. Implement updated policy and educate staff to prevent continued issues with problems identified.

4. Utilize practice management software rules engine (if available).

5. Create a culture of zero tolerance for preventable denials.

An example of an effective denials process improvement effort might include the following steps:

- **Modify Processes**
  - Identify a better tool to track enrollment process.
  - Escalate priority to insurance plans that are still pending.
  - Verify correct enrollment applications have been sent to every health plan.

- **Educate**
  - Notify the staff which health plans the provider is not enrolled with.
  - Don’t schedule appointments with patients who have these plans or schedule with a different provider.

- **Review provider enrollment process**
  - Provider is not enrolled with some insurance plans.
  - There is not a good tool for tracking the enrollment process.
  - Staff is not aware of what insurances are not enrolled.

This illustration shows an example of an improvement process after a denial reason is identified as a concern. In the top middle box, you see the identification of the denial reason “provider not enrolled.” The next box describes a review of the enrollment process to identify why denials are resulting from the process. It is identified that the provider is not enrolled with some insurances, that there is not a good tool to track the enrollment process, and that the staff involved with scheduling are not aware of what insurances the provider is enrolled with.

The next box describes what is being done to modify the process to reduce these denials including identifying a better tool to track the enrollment process so that providers get fully enrolled and escalating those that are still pending approval. It also includes identifying that correct applications have been sent to each carrier.
Questions and Answers: Denials Management

**Question:** Our billers are stating they are seeing a lot of denials but are not able to quantify specific denials. Is there a good denial tracking tool that can help us?

**Answer:** Many practice management systems (PMS) will have the ability to run a denial report. Here is an example of what a denial report may look like.

<table>
<thead>
<tr>
<th>Denial Code / Reason</th>
<th>Count</th>
<th>%</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>468 - DUPLICATE CLAIM</td>
<td>9</td>
<td>8.74%</td>
<td>$1,575.00</td>
</tr>
<tr>
<td>487 - NO PRECERT OR PRIORAUTH</td>
<td>19</td>
<td>18.45%</td>
<td>$3,325.00</td>
</tr>
<tr>
<td>597 - NOT PRIMARY PAYER</td>
<td>15</td>
<td>14.56%</td>
<td>$2,625.00</td>
</tr>
<tr>
<td>390 - PATIENT NOT INSURED BY PAYER</td>
<td>14</td>
<td>13.59%</td>
<td>$2,450.00</td>
</tr>
<tr>
<td>437 - FREQUENCY OF SERVICE</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>629 - PROVIDER NOT ENROLLED</td>
<td>15</td>
<td>14.56%</td>
<td>$2,625.00</td>
</tr>
<tr>
<td>596 - SERVICE IS NOT COVERED</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>522 - TIME LIMIT FOR FILING EXPIRED</td>
<td>4</td>
<td>3.88%</td>
<td>$700.00</td>
</tr>
<tr>
<td>532 - NOT AUTH NETWORK/PRIMARY PROV</td>
<td>7</td>
<td>6.80%</td>
<td>$1,225.00</td>
</tr>
<tr>
<td>444 - MULTIPLE PROCEDURES ON SAME DOS</td>
<td>4</td>
<td>3.88%</td>
<td>$700.00</td>
</tr>
<tr>
<td>OTHER</td>
<td>2</td>
<td>1.94%</td>
<td>$350.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>103</td>
<td></td>
<td><strong>$18,025.00</strong></td>
</tr>
</tbody>
</table>

You will notice that the name of the denial and the denial code are listed on the left-hand column. The number of denials for the time period are listed next along with the percentage of overall denials and dollar equivalent of the denials. This report will help identify what denials are most prevalent and costing the practice the most money. It will also provide a guide to prioritize the denial management improvement efforts. Here we see that one of the most significant denials that needs to be reviewed is the provider not being enrolled.
Question: What is the difference between an EOB and an RA?
Answer: While an EOB is sent to the patient, an RA is sent to the provider who billed the service.

Both types of statements provide an explanation of benefits. The content of the RA and the EOB is nearly identical with the exception of a few minor differences.

The major difference between RAs and EOBs is that an EOB contains a disclaimer stating the EOB is not a bill.

Example: For example, at the top of an EOB for Cigna, you will find the statement: “THIS IS NOT A BILL. Your healthcare professional may bill you directly for any amount you owe.”

Question: What information do RAs and EOBs contain?
Answer: In general, both RAs and EOBs contain this information:

- Information regarding the patient
- The service provider
- Any adjustments made to the claim
- The type of procedure performed
- The date the procedure was performed
- The cost of the procedure
- An explanation if the payment was denied

Additional information regarding the patient's benefits may be included as well, including particulars of the plan, such as copayments and deductibles.

Question: How can practices help ease the confusion that patients often have about EOBs?
Answer: Practices should explain to patients what the EOB will tell them and try to help them interpret it.

Practices could let their patients bring in EOBs and explain them or post explanations on their websites as a helpful service. Some practices offer education classes for patients to teach them about EOBs.

Question: How can practices utilize their RAs to streamline their processes?
Answer: All billing staff should spend time studying the reasons cited for adjustments or denials from the RA they received. Each RA message should be tracked to ensure that any patterns of inappropriate adjustments (incorrect use of a modifier, bundling issue, reduction for secondary procedure, etc.) or denials (code not covered, code bundled, demographics incorrect, not medically necessary, etc.) are addressed to evaluate processes, work to improve them as needed, and ensure maximum reimbursement.

Billers should also use RAs to compare what was paid to the published fee schedule from the insurer to ensure payments were made according to payer contracts.
**Medical:** Since a cardiac stress test (codes 93015-93018) includes multiple electrocardiograms, an electrocardiogram (code 93005 or 93010) is not separately reportable.

**Surgical:** Since a myringotomy (code 69421) requires access to the tympanic membrane (ear drum) through the external auditory canal (EAC), removal of impacted cerumen (code 69210) from the EAC is not separately reportable.

The component elements of the preoperative and postoperative work for each procedure are included component services of that procedure as a standard of medical/surgical practice. These include:

- Insertion of a central venous access device
- Cardiopulmonary monitoring
- Exposure and exploration of the surgical field

Consider this portion of the table:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>* = In existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date * = no data</th>
<th>Modifier 0 = not allowed</th>
<th>1 = allowed</th>
<th>9 = not applicable</th>
<th>PTP Edit Rationale</th>
</tr>
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<td>19960101</td>
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<td>Standards of medical / surgical practice</td>
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<td>*</td>
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<td></td>
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<td></td>
<td>Standards of medical / surgical practice</td>
<td></td>
</tr>
<tr>
<td>11042</td>
<td>11001</td>
<td></td>
<td>19960101</td>
<td>19960101</td>
<td>9</td>
<td></td>
<td>Standards of medical / surgical practice</td>
<td></td>
</tr>
<tr>
<td>11042</td>
<td>11008</td>
<td></td>
<td>20160701</td>
<td>*</td>
<td>1</td>
<td></td>
<td>CPT® code book or CMS manual coding instructions</td>
<td></td>
</tr>
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<td>11010</td>
<td>*</td>
<td>19980101</td>
<td></td>
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<td></td>
<td>Mutually exclusive procedures</td>
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<td>11042</td>
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<td></td>
<td>19960101</td>
<td>20101231</td>
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<td>HCPCS/CPT® procedure code definition</td>
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<td>*</td>
<td>0</td>
<td></td>
<td>Standards of medical / surgical practice</td>
<td></td>
</tr>
</tbody>
</table>

The NCCI file formats continue to include a Correct Coding Modifier (CCM) indicator (carrier only) for both the Comprehensive/Component Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either “0,” “1,” or “9.” The definitions of each are:

- **0** = A CCM is not allowed and will not bypass the edits.
- **1** = A CCM is allowed and will bypass the edits.
- **9** = This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

Reference the table for the examples.
National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)

The Medicare Coverage Database is a searchable database that contains all Medicare NCDs, National Coverage Analyses (NCAs), LCDs, local articles, and other information. NCAs include proposed NCD decisions. The NCD is intended to be used by Medicare contractors, providers, and other healthcare professionals.

NCDs’ statutory and policy framework are based on § 1862 of Title XVIII of the Social Security Act and Medicare regulations and rulings. The NCD Manual indicates whether specific medical services, items, treatment procedures, or technologies can be paid for by Medicare. All decisions of denial of coverage are based on §1862(a)(1) of the Act unless otherwise specifically noted.

Medicare contractors are required to follow NCDs unless an NCD does not specifically exclude or limit an indication or circumstance, or if the item or service is not mentioned at all in either the NCD or a Medicare manual. In such circumstances, the Medicare contractor can make an LCD. NCDs and LCDs are updated as they are published.

An LCD is mandated at the MAC level. The guidelines given are only applicable to that specific MAC’s jurisdiction. Medicare contractors develop the LCDs when there is no NCD or when there is a need to further define an NCD. Chapter 13 of the Medicare Program Integrity Manual contains the guidelines for LCD development. When there is an NCD and an LCD for the same procedure, the NCD takes precedence.

In response to a provision of the 21st Century Cures Act, the Centers for Medicare & Medicaid Services (CMS) revised chapter 13 of the Medicare Program Integrity Manual (PIM). The codes (ICD-10-CM, CPT®/HCPCS, Bill Type, and Revenue) are relocated from LCDs and into local coverage articles. The LCD and the Billing and Coding Article are companion documents. They will be related to each other, and MCD users can see the relationship and access the related document by navigating to the “Related Local Coverage Documents” section in either the LCD or article.

Commercial Payer Medical Policies

Commercial carriers will develop their own medical policies. These are often available on the payer’s website but only accessible with a provider login. Commercial medical policies will include much of the information available on Medicare NCDs and are typically updated through monthly newsletters from the payer.
EXAMPLE: IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICDS)

Your cardiologist replaces an existing single chamber implantable defibrillator pulse generator with a new dual chamber defibrillator, new RV lead, and existing RA lead for a Medicare patient. It seems like this should be a fairly straightforward service to report, so you submit 33241 and 33249 on your claim.

But Medicare rejects your claim. What went wrong?

First, Understand Background of ICDs

If you bill for implantable cardioverter defibrillators (ICDs), you must be aware of the change request (CR) 10865 and Publication (Pub.) 100-03 from the Medicare national coverage determination (NCD) Manual, which details CMS's final decision about the reconsideration of NCD 20.4: ICDs. In this NCD, CMS very specifically outlines six patient indications where it will cover ICDs.

ICDs defined: Cardiologists use ICDs to diagnose and treat life-threatening ventricular tachyarrhythmias (VTs). Implantable defibrillator systems include a pulse generator and electrodes, like a pacemaker system, according to the CPT® guidelines.

“This therapy has been shown in trials to improve survival and reduce sudden cardiac death in patients with certain clinical characteristics,” according to MLN Matters®.

Observe These Indications for ICDs

20.4 – Implantable Cardioverter Defibrillators (ICDs)

A. General
An ICD is an electronic device designed to diagnose and treat life-threatening ventricular tachyarrhythmias.

B. Nationally Covered Indications
Effective for services performed on or after February 15, 2018, CMS has determined that the evidence is sufficient to conclude that the use of ICDs, (also referred to as defibrillators) is reasonable and necessary:

1. Patients with a personal history of sustained Ventricular Tachyarrhythmia (VT) or cardiac arrest due to Ventricular Fibrillation (VF). Patients must have demonstrated:
   - An episode of sustained VT, either spontaneous or induced by an Electrophysiology (EP) study, not associated with an acute Myocardial Infarction (MI) and not due to a transient or reversible cause; or
   - An episode of cardiac arrest due to VF, not due to a transient or reversible cause.

2. Patients with a prior MI and a measured Left Ventricular Ejection Fraction (LVEF) ≤ 0.30. Patients must not have:
   - New York Heart Association (NYHA) classification IV heart failure; or,
   - Had a Coronary Artery Bypass Graft (CABG), or Percutaneous Coronary Intervention (PCI) with angioplasty and/or stenting, within the past three (3) months; or,
   - Had an MI within the past 40 days; or,
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.
## 1. Denials Tracking Worksheet

### Denials Tracking Worksheet

Clinic: ___________________________

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Med Rec#</th>
<th>DOS</th>
<th>Doctor</th>
<th>CPT* Code</th>
<th>ICD-10-CM Code</th>
<th>$ Charged</th>
<th>Insurance Co.</th>
<th>Corrected/Refiled</th>
<th>Denial Reason/Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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Total: ___________________________
## 2. Medicare Redetermination Request Form – 1st Level of Appeal


### MEDICARE REDETERMINATION REQUEST FORM — 1st LEVEL OF APPEAL

<table>
<thead>
<tr>
<th>Beneficiary’s name (First, Middle, Last)</th>
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<tbody>
<tr>
<td>Medicare number</td>
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<tr>
<td>Item or service you wish to appeal</td>
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<td>Date the service or item was received (mm/dd/yyyy)</td>
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<td>Date of the initial determination notice (mm/dd/yyyy) (please include a copy of the notice with this request)</td>
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<td>If you received your initial determination notice more than 120 days ago, include your reason for the late filing:</td>
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<td>Name of the Medicare contractor that made the determination (not required)</td>
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<td>Does this appeal involve an overpayment? (for providers and suppliers only)</td>
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<td>☐ Yes  ☐ No</td>
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<td>I do not agree with the determination decision on my claim because:</td>
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**Additional information Medicare should consider:**

☐ I have evidence to submit.  ☐ I do not have evidence to submit.

Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

<table>
<thead>
<tr>
<th>Person appealing:</th>
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<tbody>
<tr>
<td>☐ Beneficiary  ☐ Provider/Supplier  ☐ Representative</td>
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<td>Email of person appealing (optional)</td>
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<table>
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<th>Name of person appealing (First, Middle, Last)</th>
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<tr>
<td>Street address of person appealing</td>
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<tr>
<td>City</td>
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<td>State</td>
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<td>Zip code</td>
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<td>Telephone number of person appealing (include area code)</td>
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<td>Date of appeal (mm/dd/yyyy) (optional)</td>
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**Privacy Act Statement:** The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Security Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Centers for Medicare & Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for system no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at [https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html](https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html)

Form CMS-20027 (01/20)
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