PHYSICIAN CHECKLIST FOR APPEALING AUDIT FINDINGS

☑ Separately state and refute every erroneous audit finding.

☑ If an auditor or appellate entity makes new findings during various levels of appeals process, ensure that all new erroneous audit findings are addressed.

☑ Use any forms required by auditor or appellate entity or ensure that everything required on such forms is included.

☑ Include all clinical justifications, including, where appropriate, references to:
  - The medical record
  - CMS regulations
  - Local Coverage Determinations, National Coverage Determinations, Payer Medical Policies
  - Specialty Society Guidelines
  - The CPT® Book or Other Coding References
  - Articles or studies in the medical literature

(Note: all of these elements are not specifically required in a level 1 Medicare appeal. However, it is generally easier to compile them at the beginning of an appeal and it ensures that a physician’s strongest case is presented from the beginning.)

☑ Include a summary of the errors and your arguments.

☑ Ensure that appeal is timely filed.

In light of current moratorium on submission of Medicare appeals to the Administrative Law Judge (third level of appeal), appeals need to be filed within 30 days to avoid recoupment.

☑ Date correspondence.

☑ Number stamp all pages of information submitted.

☑ Scan or retain copies of all correspondence and information sent.

☑ Ensure appeal sent to the correct address.

☑ Send appeal via a delivery mechanism that allows tracking.

☑ Retain proof of delivery.

The information provided herein constitutes general commentary and is not intended to provide legal advice. Receipt of this checklist does not create an attorney-client relationship.