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Payer Cheat Sheet

Medicare (CMS)

Time Limits

- Initial Claim Filing: 12 months from DOS
- Appeal Deadlines:
 - First Level (Redetermination): 120 days from initial denial
 - Second Level (Reconsideration): 180 days from redetermination decision
 - Third Level (ALJ Hearing): 60 days from reconsideration decision
 - Fourth Level (Medicare Appeals Council): 60 days from ALJ decision
 - Final Level (Federal Court): 60 days from Appeals Council decision

Required Documentation

- Completed Redetermination Form CMS-20027 or written request including:
 - Beneficiary name and Medicare number
 - Specific service/item being appealed
 - Date of service
 - Reason for appeal
- Supporting medical documentation
- Proof of timely filing if applicable
- Corrected claim if billing error



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Medicare (CMS) - Continued

Common Denial Reasons & Solutions

1. Medical Necessity
 - Include detailed clinical notes
 - Reference LCD/NCD guidelines
 - Provide peer-reviewed literature support
2. Incorrect Coding
 - Review LCD/NCD policies
 - Verify code combinations
 - Include operative reports for surgical claims

Blue Cross Blue Shield

Time Limits

- Initial Claim Filing: 180 days from DOS (varies by state)
- Appeal Deadlines:
 - First Level: 180 days from denial
 - Second Level: 60 days from first appeal decision
 - External Review: 4 months from final denial



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Blue Cross Blue Shield - Continued

Required Documentation

- Appeal submission form or letter including:
 - Patient name and ID number
 - Claim number
 - Date of service
 - Provider information
 - Detailed reason for appeal
- Medical records
- Any relevant clinical guidelines or literature

Common Denial Reasons & Solutions

1. Prior Authorization

- Submit authorization number
- Include emergency documentation if applicable
- Provide medical necessity documentation

2. Network Status

- Include any network verification documentation
- Document emergency circumstances
- Reference state regulations regarding network adequacy



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United Healthcare

Time Limits

- Initial Claim Filing: 90 days from DOS
- Appeal Deadlines:
 - First Level: 180 days from denial
 - Second Level: 60 days from first appeal decision
 - External Review: Available after exhausting internal appeals

Required Documentation

- Appeal letter including:
 - Patient and provider information
 - Claim number
 - Specific denial reason being contested
- Clinical documentation
- Peer-to-peer review notes if applicable

Common Denial Reasons & Solutions

1. Bundle/Unbundle Issues

- Reference CPT coding guidelines
- Provide operative reports
- Include CCI modifier documentation

2. Medical Necessity

- Include evidence-based guidelines
- Provide prior authorization if obtained
- Document failed conservative treatment



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Aetna

Time Limits

- Initial Claim Filing: 120 days from DOS
- Appeal Deadlines:
 - First Level: 180 days from denial
 - Second Level: 60 days from first appeal decision
 - External Review: 120 days from final denial

Required Documentation

- Appeal form or letter with:
 - Member ID and claim number
 - Provider information
 - Clear appeal reason
- Supporting clinical documentation
- Any relevant correspondence

Common Denial Reasons & Solutions

1. Timely Filing

- Submit proof of timely filing
- Include EDI rejection reports
- Document any system issues

2. Pre-certification

- Include authorization documentation
- Provide emergency documentation
- Reference medical policy guidelines



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State-Specific Requirements

Note: Always verify specific requirements for your state as regulations vary regarding:

- Timely filing deadlines
- Appeal timeframes
- External review processes
- Required forms and documentation
- Network adequacy rules
- Clean claim requirements