Medicare Appeals 2015

By
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ICD-10

- We are now 2 weeks from the implementation of ICD-10.
- You should be ready to go by now.
- If you need some review to feel ready, Dr. Evan Gwilliam will be at National University of Health Sciences Saturday, September 19.
- He will be teaching ICD-10 for 5 hours and I will be teaching Medicare documentation for 5 hours.
- We will both have books available at the seminar.
- The link to register is in the notes for this webinar.

Medicare Denials

- Medicare will deny claims.
- The denial can come in the form of a claim denial, a denial as a result of a post-payment review or as a result of a RAC, ZPIC or other subcontractor review.
- How you handle these denials will have a bearing on how you are reviewed in the future.
- Medicare (like every other insurance company) tracks individual doctor's error rates and their responses to adverse decisions (such as denials and refund requests).
- Medicare uses a procedure called Progressive Corrective Action in which they allocate resources to those areas (and doctors) where they find a high level of errors.
- PCA works by progressively increasing the severity and consequences of the review until the doctor pays attention and corrects the wrong procedure causing the error.
- Appealing denials is vitally important.
- Sometimes reviewers make mistakes.
- Sometimes you are doing something wrong and don't realize it.
- Be aware of your procedures and you work through the process.
- Correct any problems that you find.
- Get help if you need it.

Step One; The Telephone Reopening

- Minor errors or omissions in an initial determination may be corrected only through the contractor's reopening process. Since it is neither cost efficient or necessary for contractors to correct clerical errors

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through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings.

- In situation where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for a reopening.
- Reopenings are a discretionary action on the part of the contractor.
- A contractor's decision to reopen a claim determination is not an initial determination and is therefore not appealable.
- Requesting a reopening does not toll the timeframe to request an appeal.
- Reopenings are separate and distinct from the appeals process.

Medicare Appeals

- There are five levels of appeal
    - Redetermination
    - Reconsideration
    - Administrative Law Judge (ALJ) Hearing
    - Departmental Appeals Board (DAB) Review
    - Federal Court Review
- Medicare has changed the rules regarding collection of overpayments.
- Even though some levels of appeal have up to a 180 day limit for filing, Medicare will start collection actions after 30 days.
- The first two levels of appeal will delay a collection action.
- Start your appeal as soon as possible.
- According to the Medicare Benefits Policy Manual, Chapter 29, Section 210, the following person or entity has appeal rights.
    - The beneficiary.
    - A participating supplier. (a physician is defined as a supplier)
    - Non-participating suppliers accepting assignment of a claim for items or services (but only for the items or services which they have billed on an assigned basis).
    - A non-participating physician not billing on an assigned basis but who may be responsible for making a refund to the beneficiary under §1842(l)(1) of the Act for services furnished to a beneficiary that are denied on the basis of section 1862(a)(1) of the Act, has party status with respect to the claim at issue.
    - A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal. See §210.1 for information on determining whether there is another party available to appeal.

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- Neither the contractor nor CMS is considered a party to an appeal at the redetermination or reconsideration levels, and therefore does not have the right to appeal or to participate as a party at this stage in the administrative appeals process.
- If you are a non-participating who has not collected from the patient then you need to get an Assignment of Appeal Rights.
- Only a provider or supplier that is not a party to the initial determination and furnished an item or service to the beneficiary may accept the transfer of a beneficiary's appeal rights for that item or service.
- You must use form CMS-20031

Appeal Cover Letter

- There is much written and taught about producing the perfect appeal letter.
- Many teachers spend considerable time on what facts should be included and the purpose for including them.
- Most of these "facts" are nothing more than a distraction from what should be the focus of the appeal; refuting the reason for the denial.
- The vast majority of denials are for "medically unnecessary care".
- The appeal should focus on "the care was medically necessary and here is the information that supports the medical necessity."
- Also, the regulations state that a cover letter is unnecessary when you use the appeal forms supplied by CMS.
- I do not recommend cover letters.

Redetermination

- A redetermination is a second look at the claim and supporting documentation and is made by a different employee.
- The time limit for filing a request for redetermination is 120 days from the date of receipt of the notice of initial determination. The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary.
- There is no minimum monetary threshold to be met for filing a redetermination.
- This is the level where you present supporting documentation.
- Appeal requests submitted electronically via a facsimile or secure Internet portal/application shall be considered to have been received in writing.
- Use Form CMS 20027 to file a request for redetermination.
- Located at; http://www.cms.hhs.gov/CMSForms/
- Click on "CMS Forms" at left of page
- The reason that you do not agree with the determination should be that; "The services rendered were medically necessary."
- Your relationship to the beneficiary is "Provider"

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- Attach supporting documentation at this time.
- Supporting documentation should include; History, initial exam, re-exam, treatment plan, outcome assessment forms from before and after disputed date of service.
- Decision must be rendered and mailed within 60 days.
- Unfavorable and partially favorable results will be sent by mail.
- Favorable results will usually be reported in the Remittance Advice or Medicare Summary Notice.

Reconsideration

- The reconsideration is the next level of appeal if your redetermination is not in your favor
- The request for reconsideration must be filed with the Qualified Independent Contractor (QIC) specified on the redetermination notice.
- The request for reconsideration must be made within 180 days of receipt of the redetermination.
- There is no minimum monetary threshold to be met for a reconsideration
- Use Form CMS 20033 to file a request for reconsideration
- Located at; http://www.cms.hhs.gov/CMSForms/
- Click on "CMS Forms" at left of page
- Your reason should be the same as for the redetermination
- If you have any additional information to send, send it now. This is your last chance.
- The QIC will request the file from the contractor and it should have everything that was used for the redetermination
- The QIC has 60 days to process the reconsideration and render a decision
- If the reconsideration is favorable, you will receive payment within 30 to 60 calendar days

Administrative Law Judge (ALJ) Hearing

- A hearing before an Administrative Law Judge (ALJ) is your next level of appeal
- "To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration."
- The request must be filed within 60 days of receipt of notice of the QIC's reconsideration and
- The amount in controversy must be more than $150.
- A key point to remember here is that you (the doctor) are the appellant if you started the appeal and took the case through the two previous steps.
- Use Form CMS 20034 for the ALJ appeal
- Located at; http://www.cms.hhs.gov/CMSForms/
- Click on "CMS Forms" at left of page
- Copies of this completed form need to go to all parties
- You (the doctor) are the appellant
- Your information (but not your name) is placed under the section marked "Provider"

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- The beneficiary's name and address is placed in the section marked "beneficiary"
- You can choose to have a hearing (which you must attend) or have a decision based on the evidence in the case.
- You may attach additional evidence but you need a very good reason why you are just now presenting it.
- Sign as the appellant.
- Questions A and B are answered as appropriate. You may appeal multiple claims and/or beneficiaries at this level
- Question C is "no" as you are the appellant
- The last two sections are not to be completed as you are not representing the beneficiary.
- Attach a copy of the reconsideration determination
- Steps in the hearing process.
- Before the hearing.
- You and your representative, if you have one, may look at the evidence in your case file and under certain circumstances, you may be able to submit new evidence.
- **It is very important that you submit any new evidence within 10 days of receiving the Notice of Hearing.**
- At the hearing.
- The ALJ explains the issues in your case and may question you and any witnesses you bring to the hearing.
- The ALJ may ask other witnesses, such as a doctor or other experts, to come to the hearing.
- You and the witnesses answer questions under oath. The hearing is informal, but we do make audio recordings.
- After the hearing.
- The ALJ issues a written decision after considering all the evidence.
- The ALJ sends you and your representative, if you have one, a copy of the decision.
- This will give you an overview of information on the ALJ review.
- For additional information go to: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf.
- The following is taken from an actual appeal of an ALJ decision:
- "ALJs and the Council are not bound by LCDs or CMS Program guidance such as manual instructions, "but will give substantial deference to these policies if they are applicable to a particular case." 42 C.F.R. § 405.1062(a). If an ALJ or the council declines to follow an LCD, the ALJs decision must explain the basis for not doing so. 42 C.F.R. § 405.1062(b)."
- This means that they can change the rules as they want.
- The good news is that they have to have justification for it.
- The context of this case is that the doctor had a previous decision of the ALJ overturned and the ALJ was displeased.

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Departmental Appeals Board (DAB) Review

- The next level of appeal is to the Departmental Appeals Board (DAB)
- You have 60 days from the date of receipt of the ALJ hearing decision
- There is no minimum dollar amount required for a DAB review
- There is no form for filing this level of appeal
- Requests for review must be made to the DAB or the ALJ Hearing Office

Federal Court Review

- This is the last level of appeal
- You have 60 days from receipt of DAB decision or declination of review by DAB to file with the US District Court
- The amount in controversy must be at least $1,460

Lawyer

- The level at which you choose to bring a lawyer into this process is completely up to you.
- The first two levels are designed to be handled by the provider or the beneficiary.

Appointing a Representative

- A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the contractor.
- A representative may be appointed at any point in the appeals process.
- The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative.
- New appeals may be initiated by the representative within the 1-year timeframe.
- You can use form CMS-1696 to appoint a representative.
- The representative must sign the CMS-1696 or other conforming written instrument **within 30 calendar days** of the date the beneficiary or other party signs in order for the appointment to be valid.

Summary

- Medicare will deny claims for a variety of reasons.
- You must appeal all denials.
- Document correctly and use the system to your advantage.

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