Medicare Appeals 2018

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E/M Codes

- Medicare is changing how they pay for Evaluation and Management Codes (exams).
- They are proposing to combine E/M level 2-4 into a single payment level.
- This information is in the 2019 Medicare Physician's Fee Schedule that will be published in the Federal Register on November 23.
- I will have more for you as more information becomes available.

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.
- You will find out about most denials through your Remittance Advice (RA) that you receive from your Medicare Administrative Contractor (MAC).
- 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 (PCA) 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 as you work through the process.
- Correct any problems that you find.
- Get help if you need it.

Medicare Reopenings

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

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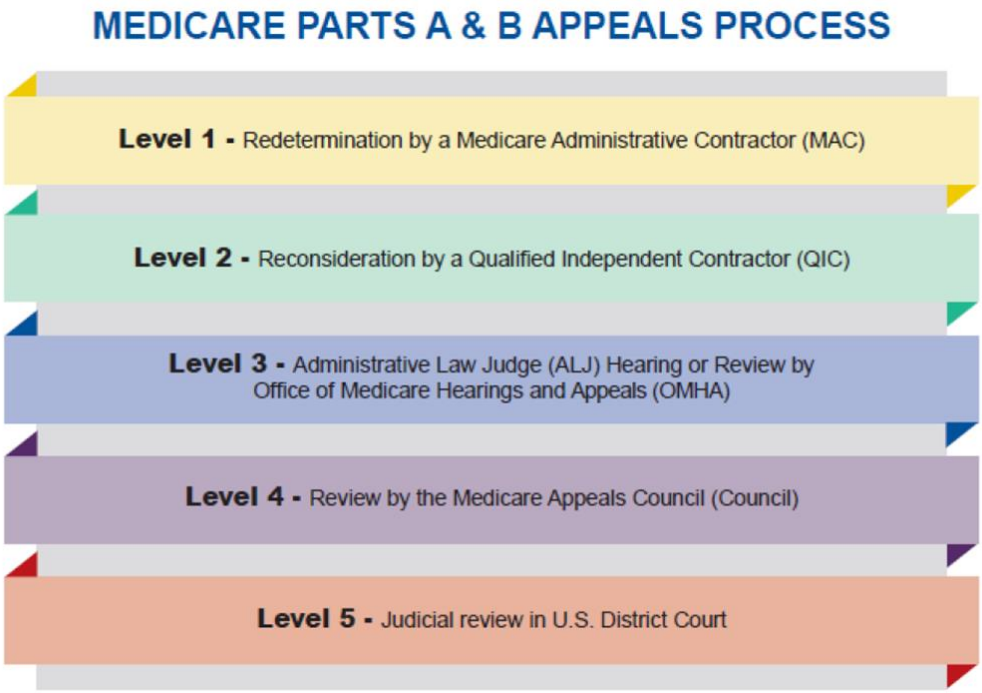
- Requesting a reopening does not toll the timeframe to request an appeal.
- Reopenings are separate and distinct from the appeals process.
- Examples of situations that would use reopening.
- Clerical errors/omissions
    - Diagnosis changes
    - Place of service changes
    - Month/day of service changes
    - Procedure code changes
    - Modifiers changes
    - Units/number(s) of service
- This is not an all-inclusive list

Medicare Appeals



- 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.

Who Can File an Appeal

- According to the Medicare Benefits Policy Manual, Chapter 29, Section 210, A person or entity with a right to appeal an initial determination is considered a party to the redetermination (as described in 42 CFR 405.906), referred to in the remainder of these instructions as a "party."
- Parties to the initial determination include:
    - Beneficiaries, who are almost always considered parties to a Medicare determination, as they are entitled to appeal any initial determination (unless the beneficiary has assigned his or her appeal rights)
    - Providers who file a claim for items or services furnished to a beneficiary.
    - NOTE: A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider or provider of service and does not have party status for an initial determination or appeal. Beneficiaries are parties to claims filed for services furnished by a non-participating provider
    - Participating suppliers and non-participating suppliers, but only with respect to items or services furnished to a beneficiary that are billed on an assignment-related basis.
- Parties to the redetermination and subsequent appeal levels include:
    - The parties to the initial determination, above;
    - NOTE: In addition to his/her own right to appeal Medicare's decision regarding an initial determination, a beneficiary is a party to any request for redetermination filed by a provider or supplier. The beneficiary is always a party to an appeal of services rendered on their behalf, at any level (except when the beneficiary has assigned his/her appeal rights to a provider or supplier).
    - A nonparticipating supplier has the same rights to appeal the contractor's determination in an unassigned claim for medical equipment and supplies if the contractor denies payment on the basis of §1862(a)(1) , §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act a s a nonparticipating or participating supplier has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service (See §1834(j)(4)), or because the beneficiary was not properly informed in writing with an Advanced Beneficiary Notice of Non Coverage (ABN) that Medicare would not pay or was unlikely to pay for the item or service. While the time limits in §310 apply for filing requests for redetermination, refunds must be made within the time limits specified in Chapter 30. An adverse advance determination of coverage under §1834(a)(15) of the Act is not an initial determination on a claim for payment for items furnished and, therefore, is not appealable;
    - 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.
- 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.

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.

Claim denials with no Appeal Rights

- Unprocessable
- Lacking information for adjudication
- Rejected up front
- Notice of Determination (NOD) letter received
- Items and services statutorily excluded from Medicare coverage

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.
- It is 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"
- 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.
- Some Medicare Administrative Contractors have their own forms for submitting a redetermination.
- Search their website under "Appeals" to find the correct form.
- Use the MAC's form if possible.
- 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.
- In 2017 42% of the redeterminations were favorable to the appellant.
- A MAC may dismiss a request for a redetermination for various reasons, some of which may be:
- If the party (or appointed representative) requests to withdraw the appeal
- If there are certain defects, such as
    - The party fails to file the request within the appropriate timeframe and did not show (or the MAC did not determine) good cause for late filing
    - The representative is not appointed properly
    - The requestor is not a proper party
- Parties to MAC dismissals have 2 options to dispute the dismissal:
    - Request that the Qualified Independent Contractor (QIC) review the dismissal
    - Request that the MAC vacate the dismissal

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 Medicare Redetermination Notice (MRN).
- 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
- In 2017 37% of the reconsiderations were favorable to the appellant.
- QIC may dismiss a reconsideration request in the following instances:
- If the party (or appointed representative) requests to withdraw the appeal; or
- If there are certain defects, such as
    - The party fails to file the request within the appropriate timeframe and did not show (or the QIC did not accept) good cause for late filing
    - The representative is not appointed properly
    - The requestor is not a proper party
- Parties to a QIC's dismissal of a request for reconsideration have 2 options if they disagree with the dismissal:
    - Request review of the dismissal by an Administrative Law Judge (ALJ,) or attorney adjudicator at the Office of Medicare Hearings and Appeals (OMHA)
    - Request that the QIC vacate the dismissal

Administrative Law Judge (ALJ) Hearing

- A hearing before an Administrative Law Judge (ALJ) is your next level of appeal.
- You have options with the hearing before the Administrative Law Judge (ALJ);
    - You can have a hearing before the ALJ where you appear (usually by phone) and present your case.
    - You can also have the ALJ simply review the records and render a decision.
    - You can have an Attorney Adjudicator review the record and render a decision.
- There are three situations where a party can request a hearing before an ALJ
    - A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration and the amount in controversy requirement is met.
    - A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the QIC's decision-making timeframe has a right to a hearing before a n ALJ if the party files a written request with the QIC to escalate the appeal to the ALJ level after the adjudication period expires and the QIC does not issue a final action within 5 days of receiving

the request for escalation. A party wishing to escalate an appeal must also meet the amount in controversy requirement.
    - A party to a QIC's dismissal of a request for reconsideration has a right to have the dismissal reviewed by an ALJ if the party meets the amount in controversy requirement.
- The amount in controversy for 2018 and 2019 is $160.00.
- You have 90 days to complete the request for a hearing.
- 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.
- Due to the tremendous backlog of cases being appealed to the ALJ level, there can be a 3 – 5 year wait to be assigned a hearing date.
- CMS is currently under a court order to have the backlog cleared up by the end of year 2022.
- Use Form OMHA-100 for the ALJ appeal
- Located at; https://www.hhs.gov/sites/default/files/OMHA-100.pdf
- Use CMS-100A form when you are appealing multiple claims.
- Place the requested information for each claim in the appropriate area.
- Multiple claims can be aggregated to meet the amount in controversy if:
- They were previously reconsidered by a QIC;
- The appellant requests aggregation of claims in the same request for an ALJ hearing; and
- The claims that a single appellant seeks to aggregate involve the delivery of similar or related services.
- Form OMHA-104 is used if you want to waive a hearing before the ALJ and have the appeal decided based on the records provided.
- The instructions are clear and easy to follow.
- You would submit this form at the time of your request for ALJ level appeal.
- There are advantages to appearing at an ALJ hearing in person.
    - You can make your case directly to the ALJ.
    - You can explain your documentation and what it means for patient care.
    - You can explain how the care was medically necessary according to Medicare regulations.
- In the end whether or not to appear at the ALJ hearing is a decision that you and your lawyer need to make.
- From the CMS Appeals website: "When a request for an ALJ hearing is filed after a QIC has issued a reconsideration, an ALJ or attorney adjudicator issues a decision, dismissal order, or remand to the QIC, as appropriate, no later than the end of the 90 calendar day period beginning on the date the request for hearing is received by the office specified in the QIC's notice of reconsideration, unless the 90 calendar day period has been extended."
- This time period is currently being extended due to the tremendous backlog of appeals.
- The system was originally designed to handle 2,000 appeals per month.
- There is currently a backlog of over 400,000 appeals.
- CMS is under a court order to have this backlog cleared by the end of 2022 and they are working on it, but it will mean a delay of years before you can appear at a hearing.

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
- You would use Form DAB-101 to file a request for review of an ALJ decision.
- The instructions are clear and easy to follow.
- The second page of the form has additional instructions and information to assist you in filing this request.

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 for 2018 must be $1,600 and for 2019 must be at least $1,630
- The amount in controversy is recalculated each year.

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.
- If you intend to take your appeal to higher levels it is wise to involve a lawyer in the earlier stages.

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.