

EXECUTIVE Summary



Changes to the Medicare Claims Appeal Process

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Overshadowed by the introduction of Medicare Part D and the implementation of Prospective Payment System (PPS) Resource Utilization Groups (RUG) refinements for skilled nursing facilities (SNFs), the changes to the Medicare claims appeals process went into effect on July 1, 2005 for claims submitted to fiscal intermediaries (FI) and January 1, 2006 for claims submitted to carriers.

On March 8, 2005, the Centers for Medicare & Medicaid Services (CMS) published the Interim Final Rule related to changes in the Medicare claims appeal procedures as mandated by Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. These changes include:

1. Establishing a uniform process for handling Medicare Part A and Part B appeals, including the introduction of a new level of appeal for Part A claims
2. Revising the time frames for filing a request for Part A and Part B appeals
3. Imposing a 30-day time frame for certain “redeterminations” made by the contractors

4. Requiring the establishment of a new appeals entity, the qualified independent contractor (QIC), to conduct “reconsiderations” of initial determinations made by contractors
5. Introduction of an “escalation” process, if specified time frames in the reconsideration process are not maintained
6. Establishing a uniform amount of \$100 in controversy threshold for Part B appeals at the Administrative Law Judge (ALJ) level
7. Imposing a 90-day time limit for conducting ALJ and Department Appeals Board (DAB) appeals
8. Imposing “de novo” review when the Medicare Appeals Council (MAC) reviews an ALJ decision.

In addition, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 required additional revisions to the Medicare claims appeal procedures. Probably the most significant requirement of the MMA is the transfer of the ALJ function from the Social Security Administration to the Department of Health and Human Services.

Those in the long-term care industry should become familiar with the appeals process and understand each level of appeal to optimize their chances of a favorable outcome should they choose to appeal denied claims. There are 5 different levels of appeals in the new process; the redetermination, the reconsideration, the ALJ, the DAB, and the Federal District Court. Each level of appeal is uniformly applied to both Medicare Part A and Medicare Part B claims under the new process.

The first level of appeal, the redetermination, formerly known as the reconsideration for Part A claims and the review for Part B claims, is requested of the contractor who originally denied the claim. A request for reconsideration must be received by the contractor no later than 120 days from the original date of denial. Once received, the contractor has 60 days to review and issue a decision related to payment or denial of the claim in question. Appellants should submit any and all available evidence they may be in possession of to assist the contractor in

processing the redetermination request.

If the redetermination decision is unfavorable to the appellant, he or she may proceed to the next level of appeal, the reconsideration. This level of appeal is new for Medicare Part A claims. A written request for reconsideration must be submitted to the appropriate QIC within 180 days of the receipt of the redetermination decision. Appellants may, at their choosing, submit additional evidence to support a claim. Once that is received, the QIC is required to make an official decision related to the request within 60 days.

During the QIC review, CMS' new regulations mandate that if a claim is being denied due to a determination that services were not reasonable and necessary for the diagnosis or treatment of an illness or injury, a QIC's reconsideration must be based on clinical experience as well as medical, technical, and scientific evidence. These claims must be reviewed by a panel of physicians or other qualified healthcare professionals. This requirement should, CMS states, produce "administrative finality" at an earlier level of the process and benefit both appellants and the Medicare program.

The third level of appeal, if required, would be to request an ALJ hearing. A request for an ALJ must be received within 60 days of the reconsideration decision. The ALJ has 90 days from receipt of the request to schedule, conduct, and submit a decision. There is a minimum amount of \$100 in controversy requirement to request an ALJ level of appeal.

The fourth and fifth levels of appeals are the DAB and the Federal District Court, respectively. Requests for both of these levels of appeal must be filed within 60 days of receipt of the previous level decision. The DAB has no minimum amount in controversy requirement, while the Federal District Court requirement is \$1,000.

No matter what the level of the appeals process, it is of importance that appellants meet the time frame requirements established under each level to ensure appropriate action is taken regarding their requests. Failure to meet the specified time frames may forfeit the ability of the facility to appeal their denial. For this reason, appellants should

establish tight controls and processes to monitor appeal level time frames.

By CMS requirements, a written request must be submitted when filing an appeal at each level of the appeals process. Although not required, CMS has developed standardized forms for requesting a redetermination (CMS 20027), reconsideration (CMS 20033), and an ALJ hearing (CMS 20034A/B). It is highly recommended that a facility use and complete the standardized form to ensure the appropriate information requested of CMS is submitted. Regardless of the form used, CMS requires the following information be included:

1. Beneficiary's name
2. Health insurance card (Medicare card) number
3. Dates of service
4. Services at issue
5. Name and signature of the party or representative of the party.

The absence of any of this information may cause dismissal of the appeal request. Submitting this required information is only the minimum amount of documentation requested by CMS. To increase a facility's chances of a favorable outcome, it is recommended to submit additional information supporting why the claim should be paid as submitted. This information may include a statement of why services should be covered; a brief clinical summary of the resident, including pertinent diagnosis and medical conditions; references to applicable regulations and guidelines; and copies of supportive documentation from the clinical record, otherwise not yet submitted.

Under the new process, CMS limits the submission of this supportive evidence up to and including the reconsideration at the QIC level. Under special circumstances, additional evidence may be accepted by the ALJ hearing if the facility can justify "good cause" in doing so.

One of the most significant changes to the appeals process, as mandated by BIPA, is the appellant's right to escalate a case to an ALJ if a QIC fails to make a timely reconsideration, or to the MAC if an ALJ hearing does not produce a timely decision on an appeal of a QIC reconsideration. It should be noted, however, that careful consideration

should be made in requesting an escalation, as an escalation will negate the mandated time frames in decisions made at the respective level of escalation. A request for escalation can significantly delay the final outcome of an appeal.

As previously mentioned, Section 993 of the MMA requires the responsibility for the functions of the ALJ to be transferred from the Social Security Administration to the Department of Health and Human Services. There will be a total of 4 ALJ offices nationwide (Irvine, Calif; Cleveland, Ohio; Arlington, Va, and Miami, Fla), and ALJ hearings will be conducted either by video telephone conference (VTC), telephone, or in person. If an in-person hearing is requested, the 90-day time frame for the ALJ to make their decision is waived. A notice of hearing will be sent to the appellant at least 20 days before the hearing.

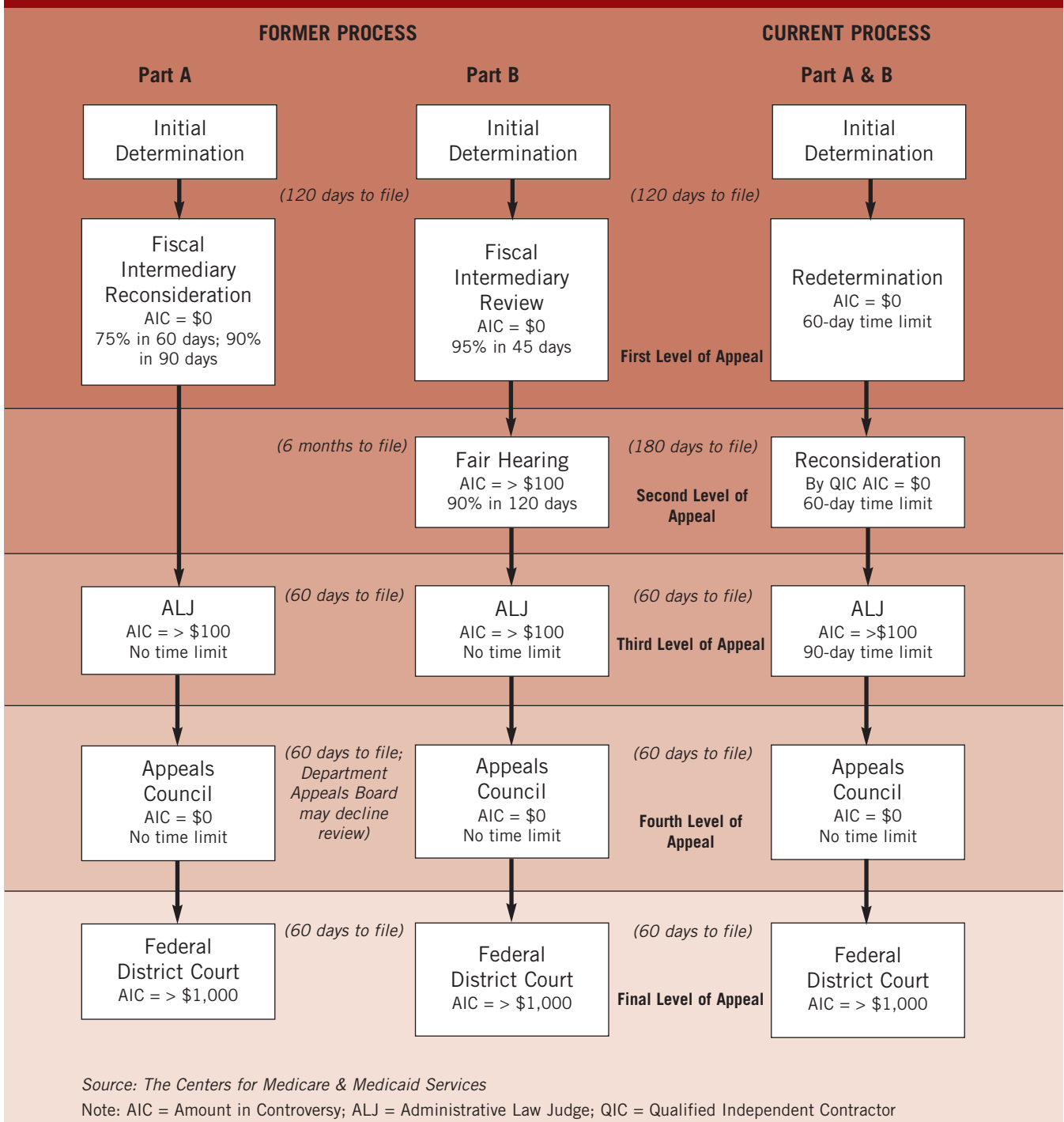
At the ALJ level, CMS and/or one of its contractors (eg, FI, QIC) may participate in the appeals process. The ALJ may request CMS involvement but may not require it. If CMS or one of its contractors elects to participate, it advises the ALJ, the appellant, and all other parties identified no later than 10 days after receiving the notice of hearing.

The effect that changes to the appeals process described above will have on the long-term care industry remains to be seen. Per the Interim Final Rule, CMS believes that the changes outlined will have little or no effect on most Medicare providers and suppliers. This belief is based on CMS statistics that reveal that only about 0.5% of all Medicare claims (1.05 billion) in 2003 were appealed. Will this continue to hold true? Will there be a bigger push to conduct more medical review? Are we already seeing a shift from Medicare Part B review to

Got a Question?

If you have a question on health-care billing and/or reimbursement, contact Managing Editor Ryan Dougherty at ryand@hmp-communications and it may be answered in a future article.

Table 1. Comparison of Former and Current (Section 1869) Fee-For-Service Appeals



Medicare Part A? Will the number of claims actually denied increase? What impact will the transfer of the ALJs to the Department of Health and Human Services have on the outcomes of appealed claims?

Answers to these questions and others remain elusive. The publication of the

Final Rule by CMS will be postponed until the outlined changes in the appeals process have been in place for some time in order to assess their effectiveness and outcomes. ■

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