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MEDICARE APPEAL PROCESS

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Medicare Appeals

All healthcare providers who treat Medicare recipients are encouraged to implement a compliance program. Compliance programs often involve a periodic sampling of claims to ensure that charges for Medicare services are correctly documented and billed. One of the challenging aspects of such efforts is reviewing the documentation to determine whether the treatment supports the level and extent of care.

Two resources that can be instrumental in these reviews are the **Office of Inspector General's (OIG's) Work Plan** for physician reviews and the **Program for Evaluating Payment Patterns Electronic Reports (PEPPER)** for hospital auditing. Both publications identify trends in billing errors which can assist providers in detecting their own areas of potential liability.

The OIG Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Counsel to the Inspector General. The Work Plan's target areas should be reviewed to determine compliance requirements and how your practice measures up.

PEPPER provides statewide comparative data to help hospitals make comparisons and detect potential sources of errors. The data—compiled and released by Quality Improvement Organizations (QIOs)—can assist hospitals in identifying potential overpayments as well as potential underpayments. To identify the QIO for your state, go to *www.medqic.org* and click on "QIO Listings".

One of the targeted areas on which PEPPER reports historical data is for one-day hospital stays. The PEPPER User's Guide provides one-day admission information in an effort to review the medical necessity of the admission and provide information to hospitals on avoiding unnecessary admissions. Readmissions are another area examined by PEPPER. A high rate of readmission should be reviewed to ensure that discharge decisions are being made in accordance with approved guidelines and that discharge instructions and follow-up care is arranged. Finally, hospitals can benefit by using the PEPPER list of high-risk diagnosis-related groups (DRGs) and the accompanying information on frequent errors related to those DRGs.

These tools are meant primarily to assist medical providers with denial prevention, but the information also can be useful in assessing Medicare denials for issues that can be appealed. Medicare appeal changes were implemented in 2005 that expanded providers' rights and guaranteed prompt responses to appeals as well as qualified, independent reviews at upper-level appeals. Limitations have been added, however, that apply to the presentation of new evidence in high-level provider appeals, so it is important to gather and reference all applicable information in the early stages of the appeal.

Claim response time

Initial determination

Initial determinations on Medicare claims must be made within 30 days on clean claims and 45 days on nonclean claims, according to 42 Code of Federal Regulation §§405.902, 405.920–405.928.

Level I: Redeterminations

The **redetermination** is the first level of appeal. It is a second look at the claim and supporting documentation, conducted by an employee of the Medicare carrier or an intermediary. The review must be done by an employee not involved in the initial claim determination. Medicare personnel must examine all issues in the claim and make a decision within 60 days from the date the request is received. The provider, supplier, or beneficiary has 120 days from the date the party received the initial determination to file a redetermination request with the contractor.

In the event of a denial, the carrier must provide the clinical or other information used to make the decision.

CMS-20027, "Medicare Redetermination Request Form," can be used to explain the basis of the appeal and is available online at *www.cms.hhs.gov/CMSForms/CMSForms/list.asp*. A Provider Inquiry/Adjustment form is not appropriate for appeal requests. Often, appeal information is too detailed to fit on the CMS-20027 form area for the explanation of the problem. Carriers and

intermediaries generally will accept an appeal letter instead of CMS-20027, but it is important to contact the carrier/intermediary and find out what identifying information is required. Typically, appeal letters are accepted as long as the identifying information is clearly referenced and includes the following:

- Beneficiary name
- Medicare health insurance claim number
- Provider name and number
- Date(s) of service for which the initial determination was issued
- Which item(s) and/or service(s) are at issue in the appeal
- Name and signature of appellant
- Date of signature (may also be required)

Level II: Reconsideration

Providers unsatisfied with a redetermination decision have 180 days to file a Level II appeal, or a **reconsideration**. Reconsideration requests must be submitted to the Qualified Independent Contractors (QICs) specified in the carrier's redetermination decision. One of the most significant changes to the appeal procedures in 2005 was the creation of QICs to handle Level II reconsideration requests. The QIC has 60 days from the date of the request for reconsideration to make a decision. If the decision is not received within this time frame, the appellant may notify the QIC and demand escalation to the Administrative Law Judge (ALJ). Once such a demand is received by the QIC, the QIC has five days to make a decision or the case must be escalated.

The reconsideration level is a crucial stage in the entire appeal process with respect to submission of supporting documentation. Under the appeal regulations, *all* evidence to support the appeal must be submitted at the reconsideration level or sooner, except in the case of "good cause for late filing of evidence." If there is no good cause, the failure to submit evidence generally prevents its introduction at subsequent levels of the appeal process. According to the comments recorded in the *Federal Register* interim rule related to the appeal changes, many healthcare appeal advocates believe that this penalty for failing to present evidence early is harsh. As a result, the Centers for Medicare & Medicaid Services (CMS) added a provision to allow beneficiary–appellants to submit documentation that was specified as missing in the notice of redetermination at any time during a pending appeal without the need for good cause. However, this exemption does not apply to providers or to beneficiaries who are represented by providers during the appeal process.

Under §405.968 of the appeal law, QICs must have sufficient medical, legal, and other expertise, including knowledge of the Medicare program, to review claim decisions. If an appeal is based on medical necessity, a panel of physicians or other appropriate healthcare professionals must consider the appeal, and the decision must be based on clinical experience, the patient's medical records, and applicable medical, technical, and scientific evidence. Although the QIC is bound by national coverage determinations, the QIC review gives providers the opportunity to discuss the patient's unique medical circumstances and the efficacy of the treatment in question with a panel of clinical peers.

In the March 8, 2005 *Federal Register*, the new rules were published along with the CMS comments regarding the changes. On page 11470, CMS indicates that the creation of the QIC appeal review was not expected to increase the number of overturned denials but was intended to instill confidence that decisions were reached fairly and consistently:

> In general, we do not anticipate that the introduction of these new appeals procedures will have a substantive impact on the final results of claims appeals; that is, there is no reason to believe that the use of QICs, or other changes required by BIPA and the MMA, will result in any change in the extent to which appeals eventually result in favorable decisions for providers, suppliers, or beneficiaries. Thus, we do not anticipate that these changes will have a quantifiable impact on Medical claims payments. From an administrative perspective, however, the introduction of better notice requirements, new independent

review entities, and mandatory physician review of medical necessity issues should increase appellants' confidence in the Medical appeals process.

QICs are bound by National Coverage Determinations, and must give substantial deference to local medical review policies, local coverage determination, CMS manuals, and other program guidance applicable to the claim.

Reopenings

Although at the same appeal level, **reopenings** are handled separately from redeterminations. A reopening involves a telephone call to the carrier in order to correct minor clerical errors and omissions. Reopenings can also be used for submitting missing documentation. A redetermination or a reopening must be requested within 120 days of the initial determination on the claim. This poses a potential problem in situations in which the provider is uncertain whether to request a redetermination or a reopening, because the time for filing each runs consecutively. If in doubt, providers should pursue a redetermination so that in the event of a redetermination denial, the provider will have recourse to pursue a Level II appeal.

Level III: ALJ review

Level III appeals are still under the jurisdiction of ALJs. However, under the old regulations, Level III appeals had no time limit for processing. Under the new regulations, all ALJ appeals must be completed within 90 days. An ALJ hearing may be conducted either on the record or in person. In an on-the-record hearing, the ALJ reviews the written case files and makes a decision without meeting with the physician. An in-person hearing requires the attendance of the provider.

Level IV: Medicare Appeals Council and Federal District Court

Level IV appeals are to be submitted to the Medicare Appeals Council. As with ALJ reviews, the Medicare Appeals Council now has 90 days to complete reviews. The Final Appeal Level is submission

of the appeal in Federal District Court.

Under the old Medicare process, appeals generally took three to five years to reach resolutions at the Medicare Appeals Council level. With new time constraints in place at each level, an appeal should take about 18 months to make its way through the entire process.

You can find a fact sheet regarding these changes at http://www.cms.hhs.gov/MLNProducts/downloads/Appeals_Factsheet.pdf or review more detailed information in Vol. 70 of the Federal Register, March 8, 2005, Pages 11420 to 11499. http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf

Medicare coding appeals

Online availability of the Medicare Correct Coding Initiative (CCI) edits now makes it much easier to determine whether claims have been coded correctly. A quick review of the Column 1/Column 2 edits (formerly comprehensive/component edits) and the mutually exclusive edits is important when appealing a bundling denial. The CCI edits are available at *www.cms.hhs.gov/NationalCorrectCodInitEd/*.

If it appears that your coding was correct, appeal the denial detailing the information gathered from the CCI Web site. Additionally, you should detail information on how the payment was calculated and what coding edits were used.

Geriatric treatment and medical necessity issues

Section 1862(a)(1)(A) of the Social Security Act provision states the following regarding restrictions to coverage availability for lack of medical necessity:

> "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services; (1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

In addition to the definition, CMS uses a number of local medical review policies, local coverage determinations, and national coverage determinations to assess the appropriateness of care. Furthermore, medically eligible code pair edits and standards of care ensure that claims can be handled on an automated basis without post-treatment medical review. Geriatric patients, however, have unique treatment challenges which do not always fall neatly into the Medicare medical necessity definition. The following factors can complicate medical decisions related to geriatric care:

- Age-related comorbidities complicating patient self-care
- Lack of adequate family or other support at home
- Limitations or inability of patient to adequately detect and report pertinent medical information
- Need to discuss patient care and pharmacopoeia management with caregiver
- Temporary, heightened anxiety over recent medical episodes
- Patient education complexities attributable to the patient's functional or cognitive limits, and the need to customize instruction and assess patient's capacity for follow-through

Appeals for lack of medical necessity of in-patient care should reference any relevant documented information related to the preceding factors, although ongoing efforts should be made to use all available resources to assist patients with these factors. One of the criticisms leveled against the use of efficiency-based guidelines or evidence-based medicine is that many studies utilized to determine treatment protocols may not have had geriatric participants. Such guidelines are therefore more appropriately applied to middle-aged populations.

Your medical necessity appeal should cite any supporting peer-review literature and, if possible, discuss various studies that have recognized the unique challenges of treating geriatric patients. If the treating physician has special credentials in geriatric treatment, this should be outlined in the appeal, as well.

The most compelling aspect of a medical necessity appeal will be that of patient medical records. Therefore, use details when describing the following points in your letter:

- Relevant history and physical, SOAP, and Clinical Pathway or Treatment Plan information, which discusses care in the context of "reasonable and necessary for the diagnosis or

treatment of illness or injury" *or* "will improve the functioning of a malformed body member"

- Previous medication/treatment efforts (including side effects, if applicable, and effectiveness or lack thereof) and patient's compliance history
- Current medications and treatment efforts (including side effects, if applicable, and effectiveness or lack thereof)
- Related hospitalizations (indicating frequency, duration, and dates of recent hospitalizations related to condition)
- Risk factors, life- or limb-threatening in nature, of patient's condition

The last component, risk factors, is where physician judgment plays an important role in justifying inpatient admits. According to a March 12, 2007 article in *Report on Medicare Compliance*, many hospitals assess the patient from inpatient admission criteria such as InterQual's "severity of illness" and "intensity of service" criteria. Physician review is just as important in determining the appropriate treatment setting, however. Joe Zebrowitz, MD, executive vice president and senior medical director of Executive Health Resources, points out that Medicare's definition of *inpatient care* in the Medicare Benefit Policy Manual for hospital services is broader than most admission criteria allow. He says the admission criteria recognize factors such as physician orders, patient history, types of facilities available, current medical needs, and hospital bylaws rather than intensity of services. He adds that this information can be persuasive in justifying the level of treatment:

> "When push comes to shove, the physicians' impression of risk is what differentiates between inpatient and outpatient and this assessment is a vital component that must be applied when the first level of InterQual screening does not say clearly 'this patient is an in-patient.' "
> (Source: *www.ehrdocs.com/pdf/news/Lack_of_Second_Level_Review.pdf*)

As with commercial appeals, one of the primary benefits of the appeal process is to aid the exchange of information. Medicare appeals at all levels should seek full disclosure of the basis of the denial and information regarding the expertise of the clinical reviewers. In addition, documentation should be submitted to support the care provided and the appeal letter should summarize the justification for care in terms of the patient's unique medical needs. References to independent peer-reviewed publications

or guidelines which support the care extended can also be highly beneficial.

If such efforts are not successful, the denial letters can be examined for any information which might be helpful regarding staff training on reimbursement issues, including the following specific points which often arise in claim appeal reviews:

> **Legibility and completeness of supporting documentation:** Were all physician notes and orders, test results, and progress reports included and readable, and were physician orders detailed in regard to specific number of x-rays needed, dosages, and other variables that affect reimbursement?
> **Appropriateness of care:** Was care rendered by an appropriately credentialed provider and at the correct level of care specified for that type of treatment?
> **Billing compliance:** Were national and local coverage determinations followed, and were claims submitted in compliance with Medicare billing instructions?

Under the serious time constraints of today's medical environment, clinicians can easily lose sight of the importance of routine matters such as detailed documentation. Staff training and ongoing oversight of documentation provide a forum for open discussion on needed improvements and collective ideas on how to best approach procedural changes. Review your organization's historical denial data and present case scenarios that illustrate the effect of proper documentation versus noncompliant documentation. Collect external denial documentation through the resources referenced to assist trainers in demonstrating that compliance challenges are industrywide but can be successfully addressed through focused attention to improvements.

References

Federal Register. Vol 70, no. 44. March 8, 2005, Pages 11420 to 11499.

Zebrowitz, J. 2007. "Lack of Second-Level Admission Review May Hinder Compliance; Frequent Audits Needed." ***Report on Medicare Compliance*** **16 (10):** ***www.ehrdocs.com/pdf/news/Lack_of_Second_Level_Review.pdf*****, March 12, 2007.**