

2010 Legal Symposium and March on Washington

Session 601. Medicare Appeals: Strategies for Success

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Basic Strategy

- Respond carefully & comprehensively
- Address eligibility and coverage
- Fully develop response related to reason for denial
 - ADR responses
 - Reopening (if applicable)
 - Redetermination
 - Reconsideration
 - ALJ
 - MAC

Basic Strategy

- Collect available information
- Review record
- Organize
- Identify need supporting information
- Copy and inventory content
- Maintain duplicate copy
- Create cover page

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Eligibility & Coverage Requirements

- Details: Session #502
- Statute and Regulations on NAHC Website under Regulatory
 - SSA§1814(a), 42 U.S.C. 1395f(a)
 - 42 CFR 409.32, 409.33(a) and (b), 409.40-49
 - <http://www.nahc.org/regulatory/home.htm>
- CMS Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 7: <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>
- Other resources: end of presentation

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Eligibility Criteria

- Goal of appeal: Defend Eligibility
 - Confined to home
 - Under care of physician
 - In need of skilled service
 - Intermittent Skilled Nursing, or PT, or SLP, or continuing OT
 - Receiving services under physician POC

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Coverage Criteria

- Goal of appeal: Defend Coverage
 - Treatment is reasonable and necessary for patient's condition
 - Inherently complex
 - Safely and effectively performed by professional or technical person
 - Or, require skill because of special medical complications

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Starting Point: Assessment

- Identify documentation needed to paint the patient's "unique clinical" picture
 - Support homebound: OASIS items, plan of care, progress notes, etc.
 - Support need for skilled services
 - Diagnoses
 - OASIS M tags/comprehensive assessment for abnormal findings
 - Clarifications/qualifications as needed
 - Caregiver availability
 - Social situation
 - Clinical progress notes

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Starting Point: Assessment

- Other Resources
 - Health history & additional assessments
 - Transfer forms, inpatient records, lab tests, medication lists, diet, etc.
 - Poly-pharmacy
 - Falls risk assessments (TUG, Tinetti, Berg, etc.)
 - Pressure ulcer assessment
 - Pain assessment

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Starting Point: Assessment

- Provide clarification if assessment information appears to be conflicting
 - Different scales
 - Different descriptors
 - Patient limitations or problems/needs not found in comprehensive assessment

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Eligibility: Plan of Care

- Specify
 - Services ordered by physician related to needs
 - Physician certification
 - Needs skilled services
 - Confined to home

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Eligibility: Homebound

- Describe why patient is homebound
 - Beneficiary's condition restricts his ability to leave home EXCEPT with
 - assistance of another person OR
 - aid of supportive device
 - NOT have to be bedridden
 - Considerable and taxing effort to leave home
 - Absences for medical care and religious services do NOT negate homebound
 - Other absences of infrequent OR short duration do not negate homebound

KEY: Can patient obtain needed health services OUTSIDE the home?

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Eligibility: Homebound

- Present supporting evidence
 - List diagnoses
 - Describe patient functional limitations and clinical status
 - Reference physician certification statement or homebound
 - Reference statute & policy
 - Narrate how statute & policy apply to THIS patient

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Eligibility: Reasonable and Necessary

- Requires skilled nursing services
 - Part-time or intermittent
 - Establish less than 7 days/wk OR finite and predictable end point for daily
 - Point out necessity as based SOLELY upon unique condition
 - WITHOUT regard chronic, terminal or long time
 - No requirement for change in condition

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Coverage: Skilled Nursing

- List services provided
- Relate services provided to assessed needs
 - Patient clinical condition
 - OASIS M items,
 - Clinical summary and notes

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Coverage: Skilled Nursing

- Relate services provided to orders
- Support by referencing
 - Applicable regulations
 - Applicable policies
- Identify patients' response
- Provide description
 - Change in plan of care
 - Ongoing needs and how addressed

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Coverage: Therapy Services

- Therapy Services - Reasonable and Necessary
 - Defend as specific, safe and effective for beneficiary's condition
 - Relate to therapy practice/CMS policies
- Relate interventions, frequency, duration to
 - Clinical condition
 - OASIS M items and therapy specific assessment
 - Functional status
 - Clinical summary and notes

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Coverage: Therapy Services

- Expectation that beneficiary will improve in reasonable period of time
 - Relate to therapy goals
 - Physician orders and goals in plan of care
 - Proof of progress toward goals
- Need skills of therapist
 - Support by referencing
 - Applicable regulations
 - Applicable policies
 - Therapy practice guidelines
 - Local Coverage Decisions

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Coverage: Dependent Services

- Reiterate existence qualifying service
- Relate to regulations and policies
 - Non-routine medical supplies
 - Relate to medical needs, coverage
 - MSW
 - Identify need/impediment to effective treatment
 - List services
 - Home health aide
 - Relate regulations and policies
 - Identify assessed need for assistance
 - Document provision hands-on care or med assistance

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Other Supporting Evidence


- Journal articles
- National and Local Coverage Decisions
- CMS Transmittals
- Physician letters
- Patient and caregiver letters
- Other

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Non-Clinical Issues

- Section 1879 Waiver of Liability
 - Denial because services
 - Reasonable and necessary OR
 - Custodial care OR
 - Not homebound
 - Not need SN on intermittent basis
 - Waiver if beneficiary and provider did not know and could not reasonably be expected to know that payment would not be made

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- Section 1870 Waiver of Recovery of Overpayment
 - If overpayment is determined
 - If payment cannot be made under section 1879
 - Deemed to be without fault
 - Determination made subsequent to 3 years after claim paid
 - Found to be without fault
 - Provider took due care in billing
 - Made full disclosure of all facts
 - Based on manual and other payment guidance, reasonable to believe payment was correct, OR promptly brought question to contractor

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Provider Appeals

- New claims appeals rules effective 5/1/05
 - Same process Parts A and B
 - New second level for Part A: QIC
 - 5 levels of appeal
- Provider appeals in own right
- If lawyer/consultant representative, need Appointment of Representative
- Reopening process for minor errors and omissions

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Timelines for Appeals and To Limit Recoupment

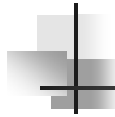
I want to:	File	Where	When	Can I Limit Recoupment of the Overpayment?	How do I Limit Recoupment?	Timeframe for Decision	Will I receive A Written Decision?
Appeal a Claim Denial (Initial Determination)	Request for Redetermination (Level 1)	Contractor identified on Initial Determination	120 days from date of Receipt	Initial Determination is a written demand for payment: Yes	Must file Request for Redetermination within 30 days from date of Initial Overpayment Demand to prevent recoupment from starting	60 days from receipt of Request for Redetermination	Fully favorable: No; shows in FSS/R.A.
				Initial Determination is Electronic or paper R. A.: No (includes ADR decision)	N/A		Partially favorable or fully unfavorable: Yes
				RAP: No	N/A		
				Cost Report: No (Claims Only)	N/A		

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Timelines for Appeals and To Limit Recoupment

I want to:	File	Where	When	Can I Limit Recoupment of the Overpayment?	How do I Limit Recoupment?	Evidence Warning	Timeframe for Decision
Appeal a Partially Favorable or Fully Unfavorable Redetermination Decision	Request for Reconsideration Decision (Level II)	QIC listed on Redetermination Decision	180 days from receipt of Redetermination Decision	Initial Determination is a written demand for payment: Yes	If Redetermination Decision fully affirms OP Decision: File Request for Reconsideration before 60 days after date of Redetermination Decision	Submit any missing documentation identified in Redetermination Decision	60 days from receipt of Request for Reconsideration
					If the Redetermination Decision is partially favorable (and reduces the OP amount): File Request for Reconsideration before 60 days after receipt of written notice of revised OP amount (but no later than 180 days from receipt of Redetermination Decision)	Submit all evidence no later than this level of appeal or be barred from submitting it later except with "good cause"	
						Exception: Testimony to be present at ALJ Hearing.	

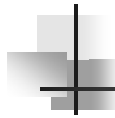
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Timelines for Appeals and To Limit Recoupment

I want to:	File	Where	When	Amount in Controversy	Format	How Do I Limit Recoupment?	Timeframe for Decision
Appeal a Partially or Fully Unfavorable Reconsideration Decision	Request for ALJ Hearing (Level III)	OMHA listed on Reconsideration Decision	60 Days from Receipt of the Reconsideration Decision	Minimum \$130 (2010)	Most via telephone; some via video-teleconference; very few in-person. All: testimony	Not available above QIC	90 days from receipt of Request for Hearing

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Timelines for Appeals and To Limit Recoupment

I want to:	File	Where	When	Amount in Controversy	Format	Timeframe for Decision
Appeal a Partially Favorable or Fully Unfavorable ALJ Decision	Request for MAC Review (Level IV)	Address listed in ALJ Decision	60 Days from receipt of ALJ's Decision	No Minimum	Written Submission	90 days from receipt of Request for Review

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Timelines for Appeals and To Limit Recoupment

I want to:	File	Where	When	Amount in Controversy	Timeframe for Decision
Appeal a Partially Favorable or Fully Unfavorable MAC Decision	Complaint with Federal District Court (Level V)	District Court where your provider is located	60 days from receipt of MAC's decision	\$1,260 (2010)	Whenever court wants to issue a decision

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Request for Redetermination

- Form CMS 20027 or include this information:
 - Written
 - Beneficiary's name, HIC number
 - Specific services and/or items appealed
 - Dates of service
 - Provider name and signature or representative of provider
 - If not use form, NGS wants on letterhead
 - Palmetto has its own appeals form:
[http://www.palmettogba.com/Palmetto/Providers.nsf/files/parta_rhhi_redetermination_formrev051409.pdf/\\$File/partarhhi_redetermination_formrev051409.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/parta_rhhi_redetermination_formrev051409.pdf/$File/partarhhi_redetermination_formrev051409.pdf)

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Request for Redetermination - Evidence

- Include with Request: evidence supporting why claim should be paid
- Evidence filed later extends decision timeframe by 14 days per submission

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Request for Redetermination

- Independent from denial staff
- Supposed to review what provider submits
- Contractor may obtain evidence on its own
- Contractor may raise and develop new issues relevant to claim
- Large cases, provider should request copy of case file

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Request for Reconsideration

- Form CMS -20033 or include this information:
 - Written
 - Beneficiary's name, HIC number
 - Specific items and/or services
 - Dates of Service
 - Provider name and signature or representative of party
 - Name of contractor that made Redetermination Decision
 - CMS website: Include copy of Redetermination Decision
- Note evidence warning on timeline
- Large cases, provider should request copy of case file

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Reconsideration

- QIC not bound by LCDs or manuals
 - Must explain per particular facts of case why not follow
 - Only applies to that case
 - Is bound by statute, regulations
- Reasonable and necessary determination must be made by medical panel
- May obtain own evidence - internet search

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Request for Administrative Law Judge Hearing

- Form CMS - 20034 A/B or include this information:
 - Name, address and beneficiary HIC number
 - Provider name and address
 - Name and address of consultant or attorney representative, if any
 - Document control number assigned by the QIC, if any
 - Dates of service
 - Reasons disagree with QIC's decision
 - Statement of any additional evidence to be submitted and date to be submitted
 - Include copy of Reconsideration Decision

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Additional evidence submitted by provider
will need "Good Cause"

- Evidence material to issue first
identified in Reconsideration Decision

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ALJ Hearing

- Medicare ALJ's
- *De Novo*
- Contractor, CMS may participate or be party
 - may file position papers, testify to clarify factual or policy issues
 - only party may call witnesses or cross-examine witnesses
 - only party may submit additional evidence
- ALJ actively questions witnesses
- May obtain own evidence - internet search

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Issues before ALJ

- All issues raised below not fully favorable to provider
- May address favorable portion of decision with notice prior to hearing

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Request for Medicare Appeals Council Review

- File on Form DAB-101 or include this information:
 - Written
 - Beneficiary's name and HIC number
 - Specific items and/or services provider to be reviewed
 - Reasons why provider disagrees with ALJ's decision
 - Dates of service
 - Date of ALJ's decision
 - Name and signature of provider or provider's representative

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MAC Review

- Own motion
 - By MAC
 - Referral by CMS or contractor who participated in ALJ hearing
 - Per CMS, decision not supported by preponderance of evidence
 - OR
 - ALJ abused his discretion
- Referral by CMS or contractor
 - Decision contains error of law material to outcome
 - OR
 - Present broad policy or procedural issue that may affect the public interest

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Judicial Review

- See timeline
- Need counsel

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RESOURCES

- Claims Appeals
- CMS Website:
http://www.cms.hhs.gov/OrgMedFFSApppeals/01_Overview.asp#TopOfPage
(Description of appeal levels, forms, timeframes, etc.)
- Regulations: 42 C.F.R. section 405.900 - 405.1140
- Medicare Claims Manual, (CMS Pub. 100-04),
Ch.29:http://www.cms.hhs.gov/manual_00c/downloads/clm104c29.pdf

RESOURCES (Cont'd)

- Claims Appeals

- Palmetto:

- [http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Regional%20Home%20Health%20Hospice%20Intermediary%20\(RHHI\)~Resources~Appeals?open](http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/Regional%20Home%20Health%20Hospice%20Intermediary%20(RHHI)~Resources~Appeals?open)

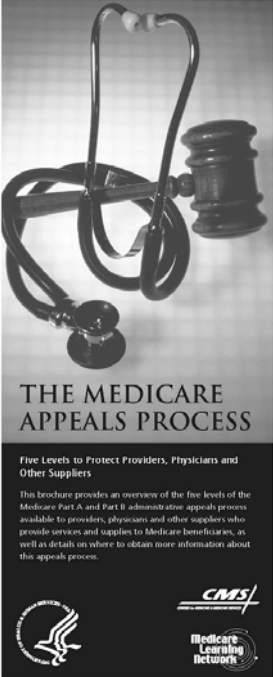
- Cahaba:

- <http://www.cahabagba.com/rhhi/appeals/index.htm>

- NGS:

- <http://www.ngsmedicare.com/content.aspx?CatID=4&DOCID=5048>

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THE MEDICARE APPEALS PROCESS

Five Levels to Protect Providers, Physicians and Other Suppliers

This brochure provides an overview of the five levels of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.

CMS

Medicare Learning Network

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Background
Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as reconsiderations, be conducted by Qualified Independent Contractors (QICs).

The reconsiderations that are conducted by the QICs have replaced the Hearing Officer Hearing process for Medicare Part B claims and established a new second level of appeal for Medicare Part A claims.

Medicare Contractors
The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies (called carriers for Part B, fiscal intermediaries (FIs) for Part A, or Medicare Administrative Contractors (MACs)) to perform many processing functions on behalf of Medicare, including local claims processing and the first level adjudication functions.

NOTE: Medicare Contracting Reform (MCR) Update—In Section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administration services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at <http://www.cms.gov/medicare/contractingreform/> on the CMS website.

Appealing Medicare Decisions

- Once an initial claim determination is made, providers, participating physicians and other suppliers have the right to appeal.
- Physicians and other suppliers who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians, or other suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 must be completed and signed by the beneficiary and the non-participating physician or supplier to transfer the beneficiary's appeal rights.
- All appeal requests must be made in writing.

Five Levels in the Appeals Process
Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- Redetermination by an FI, carrier or MAC
- Reconsideration by a QIC
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter "the Appeals Council")
- Judicial review in U.S. District Court

First Level of Appeal: Redetermination
A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination
A request for a redetermination may be filed on Form CMS-20027 available at <http://www.cms.hhs.gov/CMSForms/CMSForm411.asp#TopOfPage>. A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

NOTE: Contractors can no longer correct minor errors and omissions on claims through the appeals process. The information on how to correct minor errors and omissions, please see the following MLN Matters article, 3/2/09, located at <http://www.cms.hhs.gov/MLN200902a/downloads/MLN200902a.pdf> on the CMS website.

Second Level of Appeal: Reconsideration
A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Requesting a Reconsideration
A written reconsideration request must be filed within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN. If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party
- Name of the contractor that made the redetermination

The request should clearly explain why you disagree with the redetermination. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the evidence late.

Reconsideration Decision Notification
Reconsiderations are conducted on-the-record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain detailed information on further appeals rights if the decision is not fully favorable. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

Third Level of Appeal: Administrative Law Judge Hearing
If at least \$130* remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

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ALJ hearings are generally held by video-teleconference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing. The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Appellants may also ask the ALJ to make a decision without a hearing (on-the-record). Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and all parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party. If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council level.

***NOTE: The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2010 is \$130.**

Fourth Level of Appeal: Appeals Council Review
If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)


In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. This timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable time frame, you may ask the Appeals Council to escalate the case to the Judicial Review level.

Fifth Level of Appeal: Judicial Review in U.S. District Court
If at least \$1,260* or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

***NOTE: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2010 is \$1,260.**

For More Information
For more information about the Medicare appeals process, please visit the Medicare Fee-For-Service Appeals web page located at <http://www.cms.hhs.gov/OpMedFFS/appeals/> on the CMS website.

Medicare Learning Network
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at <http://www.cms.hhs.gov/MLNContent/> on the CMS website.



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January 2010 KN006562

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