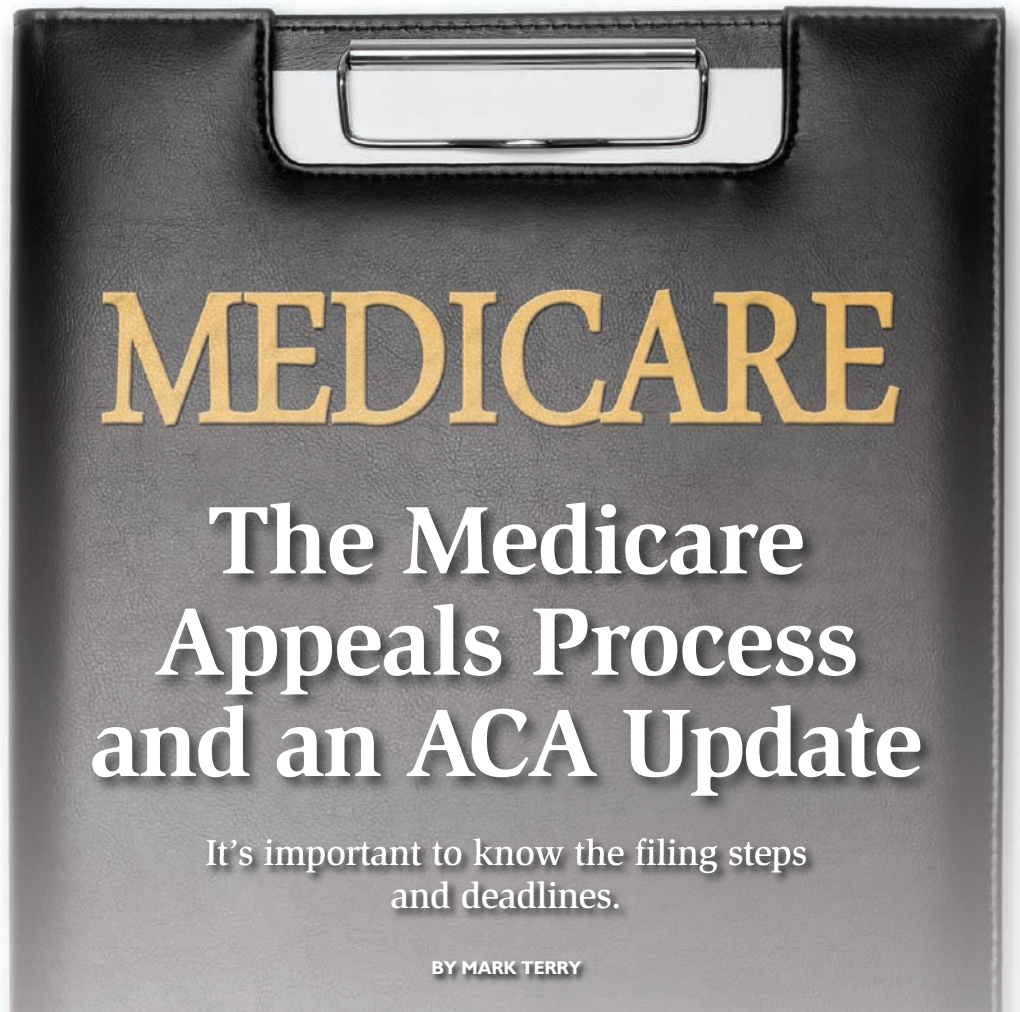

The Medicare Appeals Process and an ACA Update

It's important to know the filing steps and deadlines.

BY MARK TERRY

In the previous article we covered the appeals process in general. This article will focus on the appeals process for Medicare denials. Although every insurance company has unique procedures for appealing denials, no physician has a relationship with every insurance company, but most if not all will do business with Medicare.


Dr. Poggio

Anthony Poggio, DPM (Alameda, CA), says, "Every insurance has a different appeals process. They may have different timeframes, they may have different dollar amounts to be aware of, but generally the first level of appeal is more of a procedural appeal to make sure you do things appropriately."

Medicare, for the most part, is the same way. Medicare has five levels of appeals, although for the most part, few if any podiatrists will encounter the fourth and fifth levels. The levels are:

- Redetermination
- Reconsideration
- Administrative Law Judge
- Departmental Appeals Board Review
- Federal Court Review

Redetermination

The first level of appeal for Medicare is called Redetermination. It has to be filed within 120 days of the initial determination that your claim is being denied. There is no limit to the dollar amount involved in the claim. Dr. Frank Kase, DPM, of Burbank Podiatry Associates Group, APC, (Burbank, CA) and Chairman of the APMA Health Insurance Committee, says, "It can be anywhere from zero dollars to unlimited. You need to get the appropriate form from whoever your Medicare contractor is. Here in California it's Palmetto."


Dr. Kase

Along with the form from your Medicare contractor website, you need to submit the EOB, the data of service, the beneficiary, and any supporting documentation indicating why your appeal should be recognized and the initial determination overturned. Dr. Kase says, "You have to demonstrate support. Probably the most important thing is you need to have medical documentation that proves you were

paid inappropriately."

Dr. Poggio notes, "At this level, you typically review on procedural issues. You can correct dates, things of that nature. In theory you can address issues of medical necessity, but in my experience that needs to go to the next higher level of review."

Reconsideration

The second level of Medicare appeals review is called Reconsideration. Reconsideration is reviewed by an independent contractor who has an agreement with the Centers for Medicare and Medicaid Services (CMS). In that respect, the independent contractor is not entirely "independent," since they have a business and contractual relationship with the federal government. The reconsideration needs to be submitted within six months of the Redetermination findings. Dr. Kase says, "You need to include a copy of why your original appeal was not accepted or was overturned. Again, there's no dollar limit. You need to have all supporting documentation and you probably want to give your reasons why you disagree with the Redetermination and why it should be overturned."

The ALJ is not bound to the Local Coverage Determinations.

Dr. Poggio says that most denials that make it to this level tend to occur because the physician hasn't read the EOB or the previous denial information. "So you went through the appeal level one, it didn't go your way, and sometimes doctors get upset and don't read what the problem was. So they tend to appeal on issues that aren't necessarily the reason the claim was denied. If you don't appeal for what you're being denied for, then you will never win the appeal." He says the two primary reasons he sees appeals at this level are not sending in the appropriate documentation and not appealing the right problem.

Administrative Law Judge

The third level of Medicare appeals review is an Administrative Law Judge (ALJ). If the physician, i.e., you, has not had the denials reversed during Redetermination and Reconsideration, and you are still convinced those judgments are incorrect, you can take the appeal to an Administrative Law Judge. The Administrative Law Judge, according to Dr. Poggio, is not held to the carrier's Local Coverage Determinations (LCD). "Medicare has rules, the National Coverage Determinations (NCD), where they say X is covered.

Continued on page 104

Accountable Care Act Update

2013 marks the year in which many of the more significant provisions in the Accountable Care Act really get rolling. Although the ACA will have an impact on many areas of healthcare, two issues are of particular importance to podiatrists.

The first issue is a portion of the ACA that provides that a physician can act as an agent for the patient. For example, if you are a noncontracted physician with an insurance provider, that provider may have a policy that if you're not contracted with them, they will send reimbursement for services directly to the patient—not the physician. Dr. Kase says, "Many of us find this onerous. You have to go after the patient. Patients often cash the check. They don't want to give you the money, whatever."

However, there is now a form for the patient to sign that indicates the physician will act as the representative or agent for the patient. Dr. Kase says, "It is obligated that the insurance company recognizes you as the authorized representative for the patient, and thereby they have to send all notices of any kind of benefit determination, positive or adverse, as well as check or any kind of reimbursement, to the physician. This is huge."

The second important change is that the ACA allows podiatrists to provide a full scope of services with no discrimination allowed. In other words, if a podiatrist provides service X, which is also performed by an MD or DO, for example, the reimbursement for the service is the same, no matter which specialty provides the service. Dr. Kase says, "The health plan can set up other fee schedules. But this indicates they can't discriminate against your scope of practice in any way. You have to be allowed to provide full scope of practice if you're providing services under the ACA."

Related, although somewhat peripheral to the nondiscrimination issue, concerns the podiatric specialties' relationships with Accountable Care Organizations (ACO). The American Podiatric Medical Association (APMA) negotiated with CMS to assure podiatry would not be discriminated against in ACOs. Dr. Kase says, "We can participate equally with everybody else in an ACO and receive the benefits and losses of any other doctor in the ACO. The only thing we can't do under the ACA is we can't start an ACO, we can't be the founding member. But we can participate in every other way, shape and form." •

But the carriers, when there is a problem, whether through lack of education or in billing, can create an LCD, which will give you 'guidance,' which may have limited codes allowed, documentation restrictions, etc. You have to meet these criteria in order to win your appeal at the lower levels."

At the ALJ level, the ALJ is not bound to the Local Coverage Determinations, so he or she can go to the national policy and decide if your carrier is too restrictive or doesn't follow the NCD. The ALJ can also turn to literature studies to determine medical necessity definitions and decisions.

Dr. Kase suggests that at this level, it's preferable to get a healthcare attorney involved in the process. "Before you go to the ALJ, you want someone who is familiar with the judicial system. The ALJ is really an independent entity. He or she is not connected at all with CMS and really will be able to look objectively at the information. He or she is not beholden to anybody."

An appeal to the ALJ needs to be filed within 60 days of the independent contractor's (Reconsideration) decision and there needs to be at least $120 in question. The independent contractor at the point of turning down Reconsideration will indicate which ALJ to file an appeal with.

Kase says, "Another issue that's really important is you have to have all of your documentation in at this level of appeal. You can't change your documentation further after you to go an ALJ. That's all the information you're going to be allowed to submit."

For the most part, appeals higher than the ALJ level are fairly rare.

Departmental Appeals Board Review

The fourth level of Medicare Appeals is to the Departmental Appeals Board (DAB) Review. There is no dollar limit on this review, and it must be filed within 60 days of the ALJ decision. The DAB is a function of CMS. The DAB refers to the Board Members that the Secretary of Health and Human Services appoints, as well as referring to the larger staff organization. The CMS website says, "The DAB provides impartial, independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions." The website indicates there are four distinct DAB Divisions:

- *Alternative Dispute Resolution Division*—provides alternative dispute resolution services in appeals filed with the Board's other three Divisions, and typically involves either mediation or ombudsman services.
- *Appellate Division*—provides staff support for Board Members. The staff are typically career civil servants appointed by the HHS Secretary, and are supposed to "provide an impartial, independent review of disputes arising in a wide range of HHS programs." It also reviews certain types of ALJ decisions.
- *Civil Remedies Division*—provides staff support for the ALJs assigned to the DAB. They are "qualified under the Federal Administrative Procedure Act to conduct hearings on the record."
- *Medicare Operations Division*—provides staff support to the Administrative Appeals Judges and Appeals Officers on the Medicare Appeals Council. "The Council provides the final administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment filed by beneficiaries or health care providers/suppliers."

The most common reason for a claim to be denied is clerical—a wrong date, a wrong modifier, a typographical error.

The final level of appeal is to the federal court system. Very few physicians would go to this level and if they did so, it would presumably be because the amount of money involved was considerable.

Federal Court Review

The final level of appeal is to the federal court system. Very few physicians would go to this level and if they did so, it would presumably be because the amount of money involved was considerable. The CMS website says, "Any party to the Medicare Appeals Council (Appeals Council) decision or an appellant who requests escalation to Federal district court if the Appeals Council does not complete its review of an administrative law judge's (ALJ's) decision within the applicable adjudication period, may seek Federal court review if the amount remaining in controversy (AIC) satisfies the requirements set forth in 42 CFR §405.1006©."

The AIC is recalculated every year. For 2013, the AIC threshold is $1,400. Federal Court Review must be requested within 60 days of receiving the Medicare Appeals Council's decision.

Dr. Poggio says, "The higher level appeals are expensive. It's not just legal fees you're spending, but you're spending office time and it's costing you more and more money.

Continued on page 105

So the dollar amounts involved have to be worth it if you're going to spend, for example, $500 to get $400. Some people do it on principle, which is fine, but you've got to know when to cut your losses. At the federal level, there are more rules and more attorneys."

Medicare Advantage

Some physicians will have an arrangement with Medicare Advantage, which is an HMO plan. Typically, any appeals for Medicare Advantage plans go through the HMO's appeals process. Dr. Poggio says, "The Medicare Advantage plans have to give you what Medicare gives you. You can't get less. You may get more, but not less. When you go through the appeals process, you generally go through the HMO, so you have to work through their protocols and be aware of them. But medical necessity is still medical necessity. You can't make your own rules, you have to follow the same rules."

Medicare Appeals Good Practices

The most common reason for a claim to be denied is clerical—a wrong date, a wrong modifier, a typographical error. These are generally easy to fix, and can often be fixed via a telephone call, whether through Medicare or through a private insurer. The second most common cause for denial has to do with medical necessity issues. Documentation is key. The push for health information technology (HIT) and the use of electronic health records (EHR) is going to emphasize the need for critical documentation and proper coding. Learning to do it properly will minimize the need for appeals. Learning from denials and making corrective actions in your office and practice will minimize future denials and appeals.

Dr. Poggio says, "Use the denial and the appeal, the whole process, as an educational tool. If you do that you will get ahead of the game. You may lose that claim, but you're going to win a lot, because if you lose because of poor documentation, then learn to document correctly. You may win the appeal today, but if you don't learn to document correctly, you're going to lose every claim from there on forward. Turn it into a positive so you don't get further denials and in the long run you'll end up winning, even though you lose the claim." **PM**

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