



WISCONSIN HOSPITAL
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MEDICARE FEE-FOR-SERVICE APPEALS PROCESS

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The Centers for Medicare & Medicaid Services (CMS) contractors' hospital audit activity has undergone some recent changes. The Quality Improvement Organization's 9th Scope of Work, began August 1, 2008 and will no longer include the performance of the majority of utilization review. This work is being transitioned to Medicare fiscal intermediaries (FIs) and Part A and B Medicare administrative contractors (A/B MACs). The Medicare Recovery Audit Contractor (RAC) program is being phased in throughout the United States. On February 4, 2009, a protest by unsuccessful bidders was settled and implementation of the permanent program began moving forward. In addition to FIs, A/B MACs, QIOs and RACs audit activity can be conducted by the Department of Health and Human Services Office of Inspector General and CMS' Certified Error Rate Testing (CERT) contractor. Furthermore, Program Safeguard Contractors (PSCs) are being transitioned to seven Zone Program Integrity Contractors (ZPICs).

Given these changes, an increase in audit activity will likely occur resulting in more Medicare claim denials, leading to the increasing need for hospitals and other providers to determine if the denials can be successfully appealed. The Medicare fee-for-service appeal process has five levels with each level having its own purpose, procedural steps, review entity, filing deadlines, recoupment time frames, and other characteristics. Therefore, providers need to have a thorough understanding to ensure appeal opportunities are not forfeited.

This article will review the five-levels in the Medicare fee-for-service Part A and Part B appeals process. The levels of appeal, outlined in Attachment A, are:

First Level	•Redetermination by a Medicare carrier, FI, or MAC
Second Level	•Reconsideration by a Qualified Independent Contractor (QIC)
Third Level	•Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
Fourth Level	•Review by the Medicare Appeals Council
Fifth Level	•Judicial review in Federal District Court

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1869 of the Social Security Act, significantly changing the Medicare claims appeal procedures. In an interim final rule, published on March 5, 2005, the BIPA amendment required the establishment of a uniform process for handling Medicare Part A and Part B appeals, revised the time frames for filing an appeal, introduced a new level of appeal for Part A claims, and established a new appeal entity called a Qualified Independent Contractor (QIC). Further modification of this section was authorized by Congress in the Medicare Modernization Act of 2003 (MMA). A proposed rule on the MMA changes was issued in September 2006. Although a final rule has yet to be issued, CMS has partially implemented changes mandated by the MMA.

THE FIVE-LEVEL APPEAL PROCESS

Level 1 - Redetermination

- A request for redetermination must be filed within 120 days from receipt of the first demand letter. A redetermination request is submitted to the claims processing contractor. The contractor will issue a decision within 60 days of receipt of the redetermination request. New evidence may be submitted at this level of appeal. Submission of additional information after the request for redetermination will extend the contractor's decision-making timeframe by 14 calendar days.
- A redetermination includes an independent review of the initial determination conducted by an individual who was not involved in the initial determination. The Medicare claims processing contractor will review the evidence and finding on which the initial determination was based and any additional evidence submitted.

Level 2 - Reconsideration

- A reconsideration must be filed within 180 days of receipt of the notice of redetermination. This request is submitted to the QIC, along with any additional information. *This is the last opportunity for providers to submit new evidence during the appeal process.*
- The QIC will render a decision within 60 days of receipt of the request. Submission of additional information will extend the time period by 14 calendar days. If the QIC fails to render a decision within this timeframe, the provider has the right to escalate the case to the next level of appeal, an ALJ hearing.
- Upon receipt of the request, the QIC will request the case file from the contractor who completed the redetermination. Reconsiderations are an independent on-the-record review of the initial determination, including the redetermination and all issues related to the claim. For medical necessity issues, QIC's reconsideration process must involve a review by a panel of physicians or other health care professionals. QICs are not bound by local coverage determinations (LCD), local medical review policies (LMRPs), or CMS program guidance, such as program memoranda and manual instructions, but must give substantial deference to these policies if they are applicable to a particular case. The QIC may decline to follow a policy if it determines the policy does not apply to the facts of the particular case.

Level 3 - Administrative Law Judge

- A request for an ALJ hearing must be filed within 60 days of receipt of the reconsideration. For 2009, a minimum of \$120 must remain in controversy following a QIC's decision in order to request an ALJ hearing. In general, ALJ hearings are held by video-teleconference or telephone. An in-person hearing may be requested if good cause is demonstrated.
- Like the QIC, the ALJ is not bound by LCDs, LMRPs, or CMS program guidance, but will give substantial deference to these policies if they are applicable to a particular case. If the ALJ's decision is wholly favorable, it may issue a decision without prior notice or hearing.
- The ALJ must issue a decision within 90 days of receipt of the hearing request. The timeframe may be extended for a variety of reasons including the case being escalated from the reconsideration level. If the ALJ does not issue a decision within the specified timeframe, the case can be escalated to the Appeals Council Review.

Level 4 - Medicare Appeals Council Review

- The Medicare Appeals Council Review does not require a minimum amount of money in controversy. A provider can request a review by a Medicare Appeals Council Review if the ALJ resulted in an unfavorable decision. The request must be submitted within 60 days of receipt of the ALJ's decision. The Appeals Council Review can also occur if the council decides on its own motion to review a decision or dismissal issued by ALJ. In addition, CMS or any CMS contractor may refer a case to the Medicare Appeals Council if the decision or dismissal contained an error of law material to the outcome of the claim, or presents a broad policy or procedural issue affecting public interest. CMS's referral must be filed within 60 days of the ALJ hearing.
- The Medicare Appeals Council will consider all of the evidence in the administrative record and will review the ALJ's decision *denovo*-the Appeals Council will take a fresh look at the facts of the case. New evidence cannot be brought forward without good cause. The Appeals Council will issue a decision within 90 days of receipt of a request. This timeframe may also be extended for various reasons, including the case being escalated from an ALJ hearing. If a decision is not made within the required timeframe, the case can be escalated to the fifth level of appeal.

Level 5 - Judicial Review in U.S. District Court

- Request for a Judicial Review must be filed within 60 days of receipt of the Appeals Council's decision, and for 2009, there must be at least \$1,220 in controversy. There is no specified time period for a decision to be rendered.

DENIAL PROCESS

A Medicare contractor's decision may be overturned through the administrative appeals process, outlined below, or through the reopening process, discussed later in this article.

Demand Letter: Following an audit, the Medicare reviewing entity will notify a provider of a payment denial by issuing a demand letter that will explain:

- How the overpayment arose
- The amount of the overpayment
- How the overpayment was calculated
- Why the original payment was not correct
- Why the provider knew or should have known the items or services would not be covered or why the provider was not found to be without fault in causing the overpayment
- The recoupment process will begin on day 41 from the date of the demand letter

The demand letter will also inform the provider they may submit a rebuttal statement to any proposed recoupment action. *This rebuttal statement is not considered a request for an appeal.* In order to stop recoupment under the provisions of Section 935 of the MMA, a valid request for an appeal must be submitted within 30 days from the date of the demand letter.

When the provider receives the demand letter, the time period for requesting an appeal and the recoupment time frame will begin. The provider will also receive a remittance advice notice from the claim processing contractor indicating the overpayment amount and pending recoupment date. The electronic advice notice will be sent on the same day as the demand letter.

Rebuttal Process: To rebut any proposed recoupment action, the hospital must submit a statement within 15 days of the initial demand letter. The rebuttal process offers a provider the opportunity to establish why the proposed recoupment should not take place. Based on the rebuttal statement, a Medicare contractor may determine to proceed with the recoupment or overturn the denial and stop the recoupment. The rebuttal statement **does not** serve as a request for an appeal; therefore, a provider must submit a formal request. The Medicare contractor must consider the submitted information within 15 days from receipt of the statement.

Time frames for submission of appeals: Although the time frame for filing an appeal varies for each level, the time limit for requesting an appeal by mail, allows 5 additional days beyond the time limit from the date of the notice. Time limits can be extended if a provider can show good cause for late filing. Good cause for a delay may be shown by proving the provider received incorrect or incomplete information about the claim and/or appeal or circumstances beyond the control of the provider existed.

STOPPING RECOUPMENT

An appeal can result in a fully favorable, partially favorable, or an unfavorable decision. In a **fully favorable decision**, the Medicare contractor will adjust the payment and amount of interest charged. The provider will be reimbursed for covered items and services; if applicable, recouped funds and interest will be repaid. For a **partially favorable or unfavorable decision**, the Medicare contractor will recalculate the payment amount and recoup overpayments as appropriate.

Section 935 of the MMA amended Title XVIII of the Social Security Act changed how overpayments are recouped. Recoupment can be stopped at appeal levels one and two if certain requirements are met. This process is described in CMS Transmittal 141, dated September 12, 2008. A provider can stop recoupment by submitting a valid, timely request for an appeal during the first and second level of the process. Upon receipt, the Medicare contractor will cease recoupment; however, if funds were recouped prior to the appeal request, the money will probably be retained pending the appeal decision.

Recoupment can begin on day 41 following receipt of the initial demand letter unless a valid request for a redetermination is filed within 30 days from the date of the demand letter. To stop recoupment for a partial or fully unfavorable redetermination decision, a valid request for reconsideration must be submitted within 60 days of receipt of the redetermination decision. Recoupment can begin on day 76 following receipt of a partially or wholly unfavorable redetermination unless a valid, timely request for appeal is submitted. If the QIC decision is partially or fully unfavorable, recoupment may begin on day 30 following the date of notification.

REPAYMENT

Repayment is required when a provider chooses not to pursue an appeal of a Medicare claim denial, when the provider chooses to discontinue the appeal by not proceeding to the next level, or withdrawing an appeal request. Payment, along with interest accrued from the day of the initial demand letter, is due immediately upon deciding to not pursue or discontinue the appeal process. The provider may submit a written request for an extended repayment schedule. The other options are submitting a check for the overpayment amount or if payment is not received in full, the money will be recouped from future Medicare payments.

ACCRUAL OF INTEREST

Although recoupment can be stopped, interest begins to accrue upon issuance of the demand letter. Interest will not accrue if the provider paid the denied amount prior to the 30th day following receipt of the first demand letter or an appeal resulted in a favorable determination.

MMA Section 935 describes how interest is paid to providers when an overpayment decision is reversed at the ALJ or further appeal levels. Interest is paid to a provider if the appeal results in a partial or full reversal and recouped funds have been retained. The contractor will have 30 days following the final determination date to calculate and refund the provider. Interest is only paid on the recouped principal. To calculate the 935 interest amount, divide the interest rate by 12, multiply this amount by the number of months the money was held, the sum is then multiply by the amount recouped.

$$\begin{aligned} \text{Interest rate} / 12 &= n \\ n * \# \text{ of months held} &= x \\ x * \$ \text{ recouped} &= \text{interest owed} \end{aligned}$$

The recoupment periods—defined as Medicare possessing the recouped funds—are calculated in 30-day periods; interest is not paid for periods of less than 30 days. Interest is calculated for each 30-day period using the interest Rate in Effect on the date of revised determination. The interest rate, fixed by the Secretary of the Treasury, is the higher of the following two rates: the rate after taking into consideration private consumer rates of interest, or the current value of funds rates. The interest rate may be updated on a quarterly basis. The interest rate as of April 16, 2009, published in CMS Transmittal 151, was 11.00%.

Payments made by a provider are not recoupments and are not subject to section 935 interest.

REOPENING PROCESS

A Medicare contractor may reopen an initial determination when good cause exists. An initial determination can be reopened up to four years from the initial determination date. Good cause exists when there is new and material evidence or there was an error on the face of the evidence used to make the initial determination. New and material evidence includes evidence not readily available or known to the person or entity at the time of the initial decision. This new evidence may result in a different conclusion than the initial decision. A contractor's decision to reopen or the refusal to reopen, based on good cause, is not subject to appeal. Good cause must indicate the evidence was new and material from the perspective of the entity initiating the reopening. The evidence must not have been readily available or known to exist at the time of the determination or it must show an error or fraud was involved in the payment or appeal decision.

RAC AUDITS

CMS has begun the process of phasing in the permanent RAC program. Appeals of RAC denials will follow the same five-level appeal process previously described. Adjusted claims or recoupment of improper payments will be conducted by the Medicare claims processing contractor.

The RACs will be performing two types of review, automated and complex. Automated reviews will identify payment errors through the review of claims data. A complex review involves medical record review. For overpayments, the RACs will issue a review decision letter and a demand letter. In addition, the RACs will notify the applicable Medicare contractor of the payment error. The remark code N432-adjustment based on a RAC audit-will appear on the remittance advice to identify the payment error.

The time period for requesting an appeal begins upon receipt of the initial demand letter. In addition to the appeals and rebuttal processes, the RAC program includes a discussion period. Providers are encouraged to use the discussion



period to seek information regarding the denial or to bring forth information to support the claim. The discussion period and rebuttal process do not constitute an appeal. The providers must submit a formal written request for appeal.

CONCLUSION

The receipt of a Medicare claim denial will require prompt attention from the provider to determine if an appeal should be requested. When appealing a claim, timely action to stop recoupment must be considered. Proper education of staff, along with a defined process, will ensure appeal requests are processed appropriately and timely.

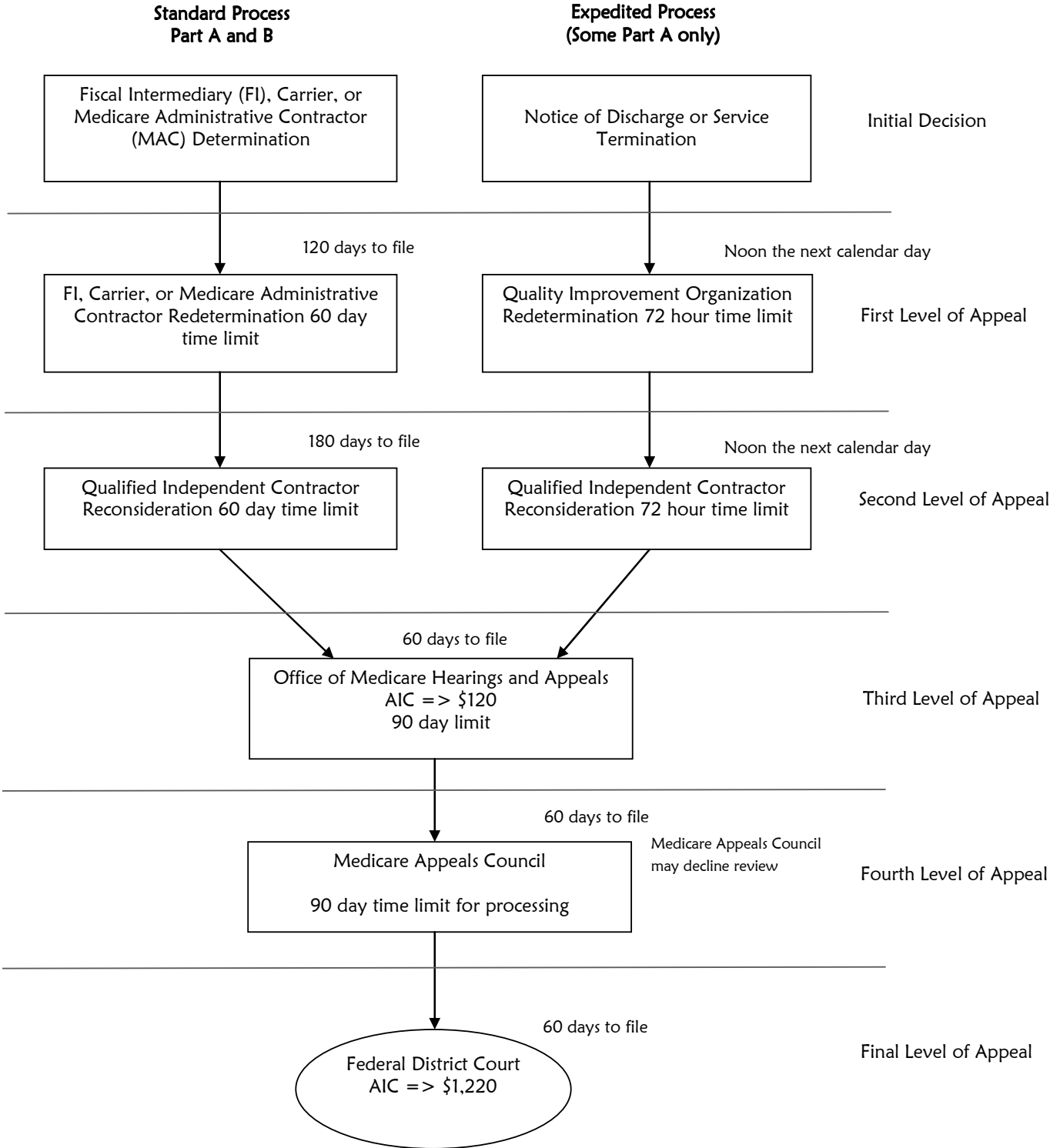
Any questions related to the information contained within this article may be directed to Amphion Medical Solutions at 888-830-2644 or Experts@amphionmedical.com.

Amphion Medical Solutions offers hands-on, personal support for our clients. Our management team consists solely of past HIM directors and Utilization Management consultants. Four of our staff were recently certified through the National Medicare RAC Summit Training Program. As HIM and UM professionals we understand your needs. Amphion offers a full array of coding, RAC services, core measure abstraction, UM/UR and medical transcription services for every size hospital, clinic and ER group. Whether you need short-term or long-term help, Amphion has a solution for you.



Attachment A

Original Medicare (Parts A and B Fee-For-Service) Appeals Process



AIC = Amount in Controversy

References

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