

A large, stylized American flag with a soft, glowing effect, waving in the background. The stars and stripes are clearly visible, and the overall tone is patriotic and professional.

**Medicare Appeals  
AHA Member Calls  
April 22 and May 12, 2009**



# Call Agenda

## **An Overview of the Medicare Appeals Process**

**Peter Thomas & Christina Hughes**

Powers, Pyle, Sutter & Verville

Washington DC

- The Mechanics of the Medicare Administrative Appeals
- Recent Changes to the Medicare Appeals Process re: Recoupment
- How are RAC appeals different?

## **2) A Case Study on Managing Medicare Appeals**

**Kathy Skrzypczak**

Martin Memorial Health System, Inc.

Stuart, Florida

## **3) Group Discussion**



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# **An Overview of the Medicare Appeals Process**

**Peter Thomas, Christina Hughes  
And Ron Connelly**

Powers Pyles Sutter & Verville, PC

Washington, DC

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# The Appeals Process

- The gateway to the appeals process is through the primary contractor for the underlying claim:
  - FI/MAC
  - DME MAC
- In addition to appealing, providers may also pursue the rebuttal process
  - 15 days to submit a written statement to primary contractor disputing the proposed recoupment
  - Does not effect appeal process deadlines



# Beginning the Appeals Process

- Receipt of the original demand letter triggers first stage of appeal rights
- Timeframes for filing of later appeals begin when a decision letter from the lower level is received
- Appeals must be received by the decision-making entity on or before the end of the timeframe for filing

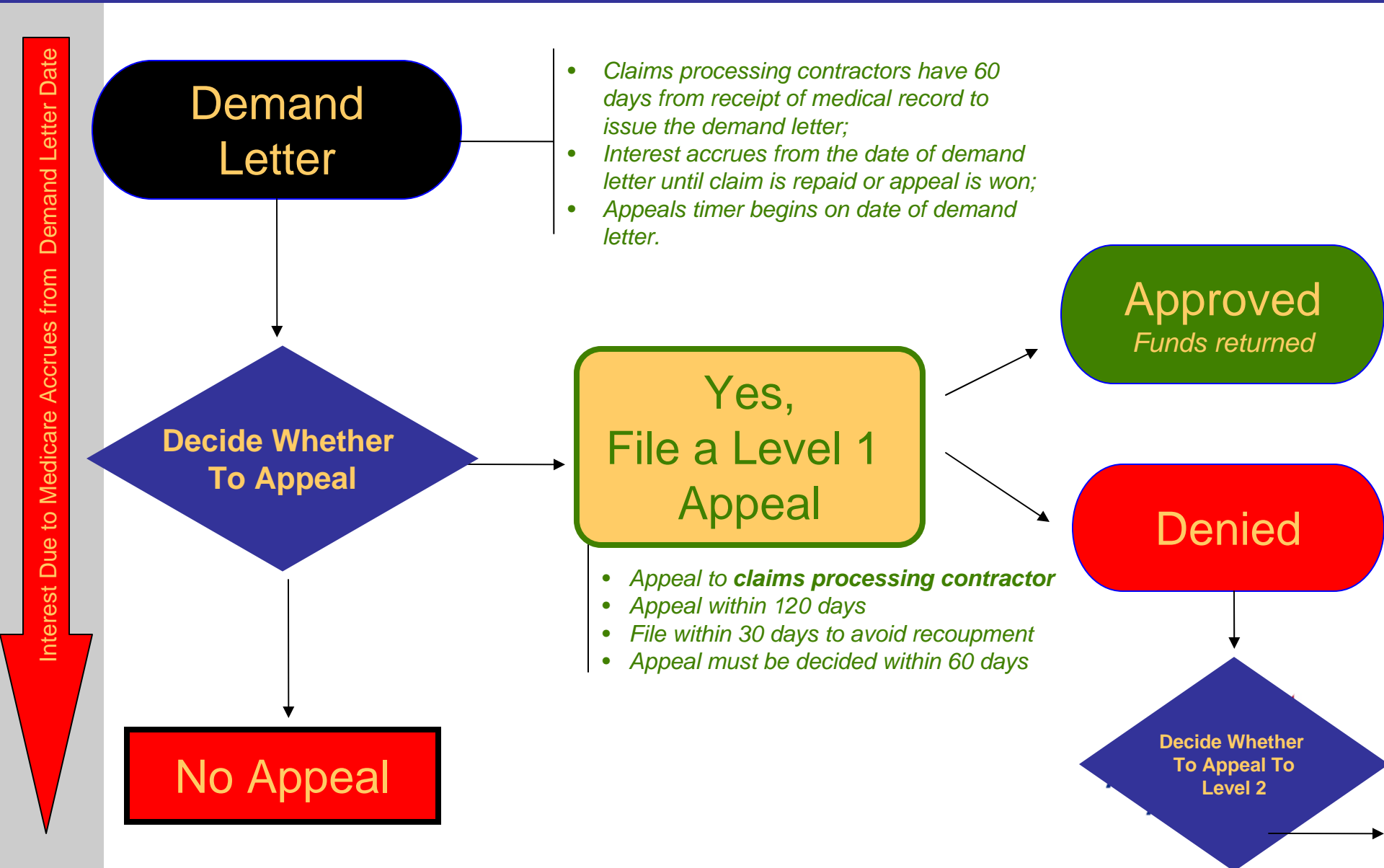


# Level 1: Redetermination

- Provider must file within 120 days of receiving the demand letter
- Appeal must be received by contractor before deadline
- Provider may submit new evidence (including the entire medical record)
- Contractor has 60 days to issue a decision
  - Must explain reason(s) for denial
  - Must include explanation of appeal rights
- No option to escalate



# Level 1 Appeals – Claims Processing Contractor

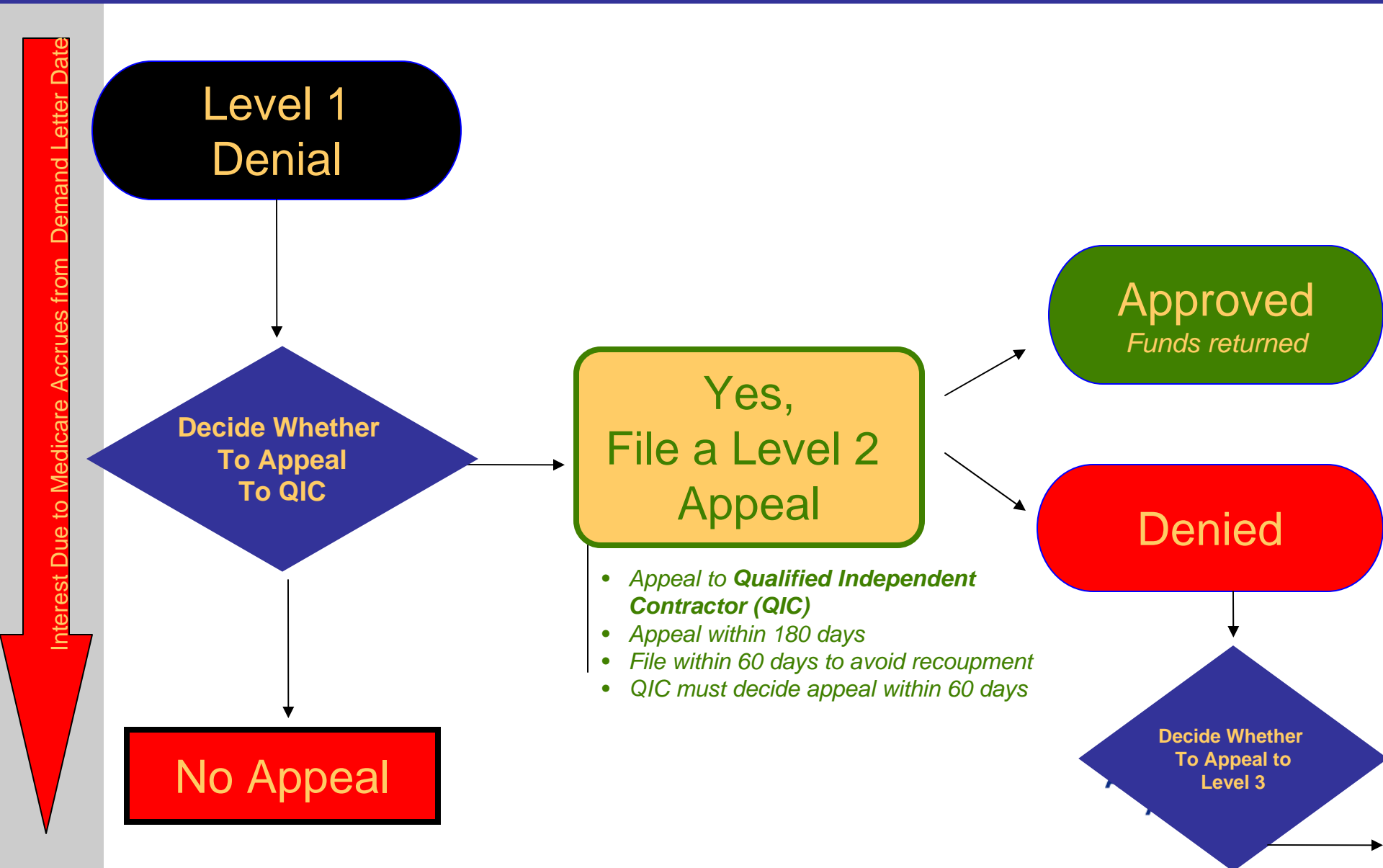


# Level 2: Reconsideration

- Provider must file within 180 days of receiving redetermination decision (5-day presumption)
- Involves independent medical review
- Provider may present new evidence BUT this is the last stage for doing so
- QIC has 60 days to issue a decision
- Escalation to ALJ allowed if the timeframe is exceeded by the QIC



# Level 2 Appeals – QIC

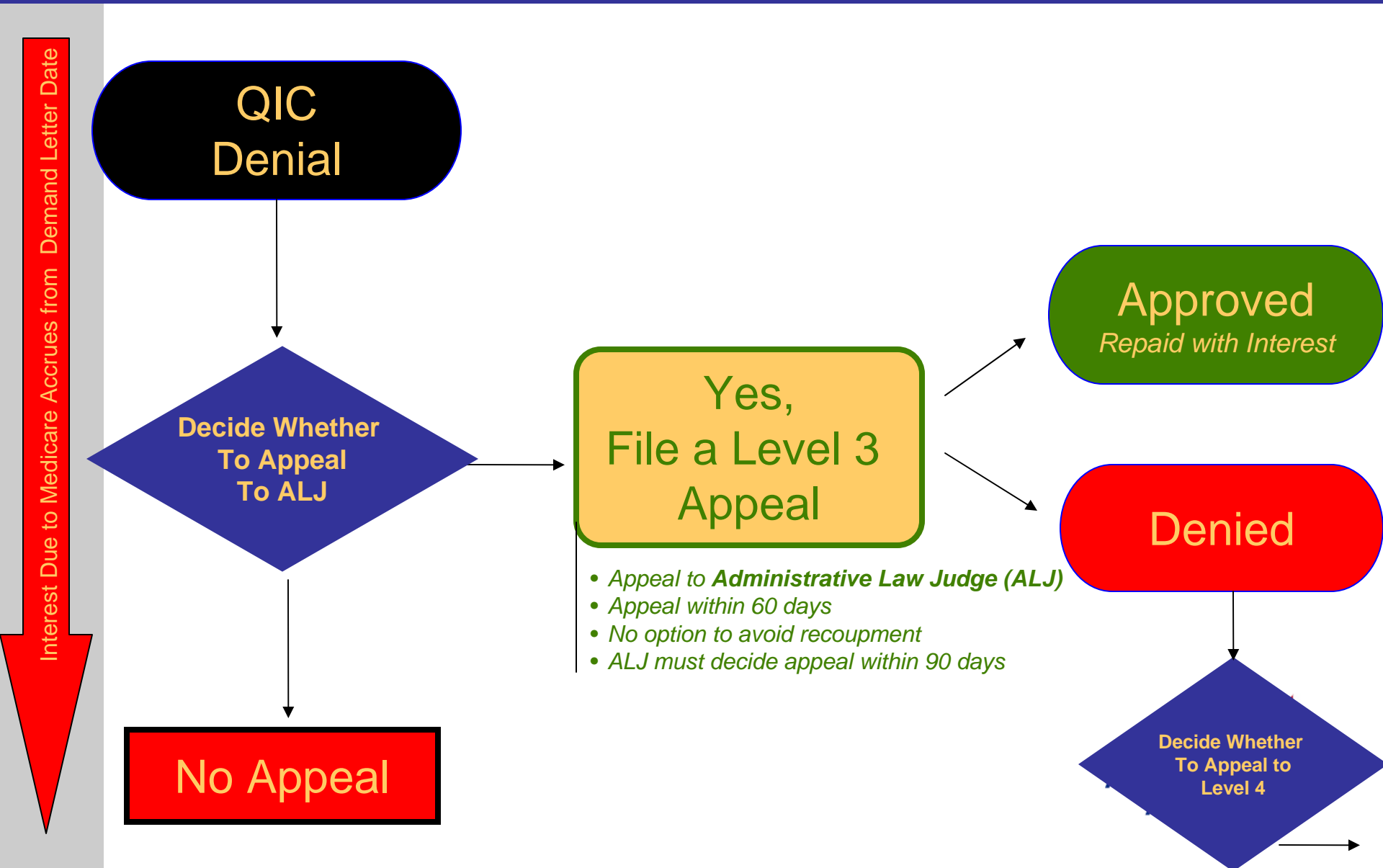


# Level 3: ALJ Hearing

- Provider must request hearing within 60 days of receiving QIC decision (5-day presumption)
- Must have a minimum of \$120 dollars in dispute
- No new evidence can be admitted at this stage without good cause
- ALJ has 90 days from the date of receiving the hearing request to issue a decision, except where claim was escalated (180 days)
- Provider may request escalation to Council if ALJ fails to adhere to timeframe
- Multiple types of hearings available



# Level 3 Appeals – ALJ

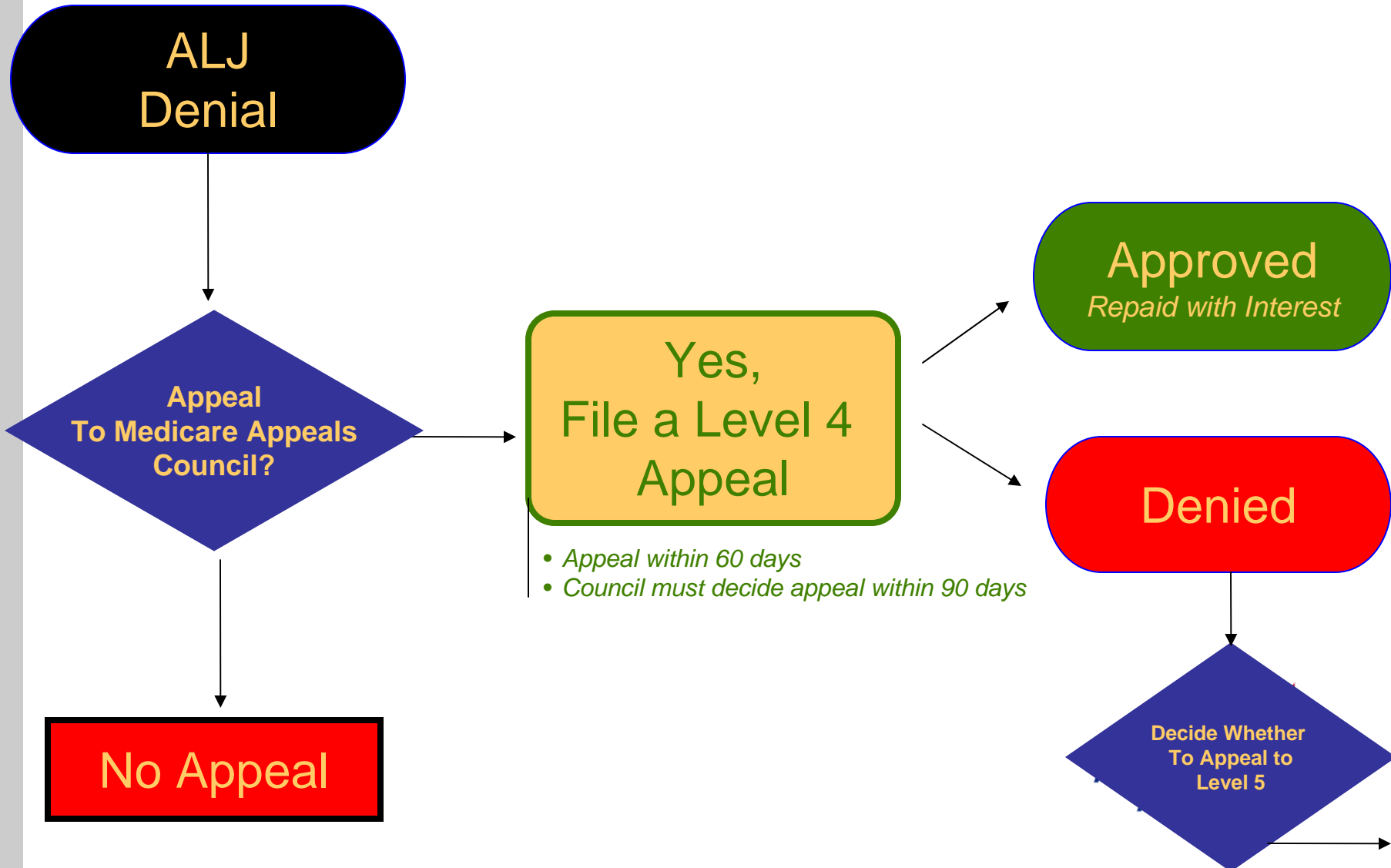


# Level 4: Medicare Appeals Council

- Three ways to reach Council:
  - Provider may file within 60 days of receiving ALJ decision
  - CMS can refer for review – Council has discretion whether or not to review
  - Council can review case on its own motion
- No new evidence may be presented at this stage
- Generally no hearing is held, though one may be requested by the provider
- Council must issue a decision within 90 days
- Escalation to federal court is allowed where the timeframe is exceeded by the Council



# Level 4 Appeals – Medicare Appeals Council

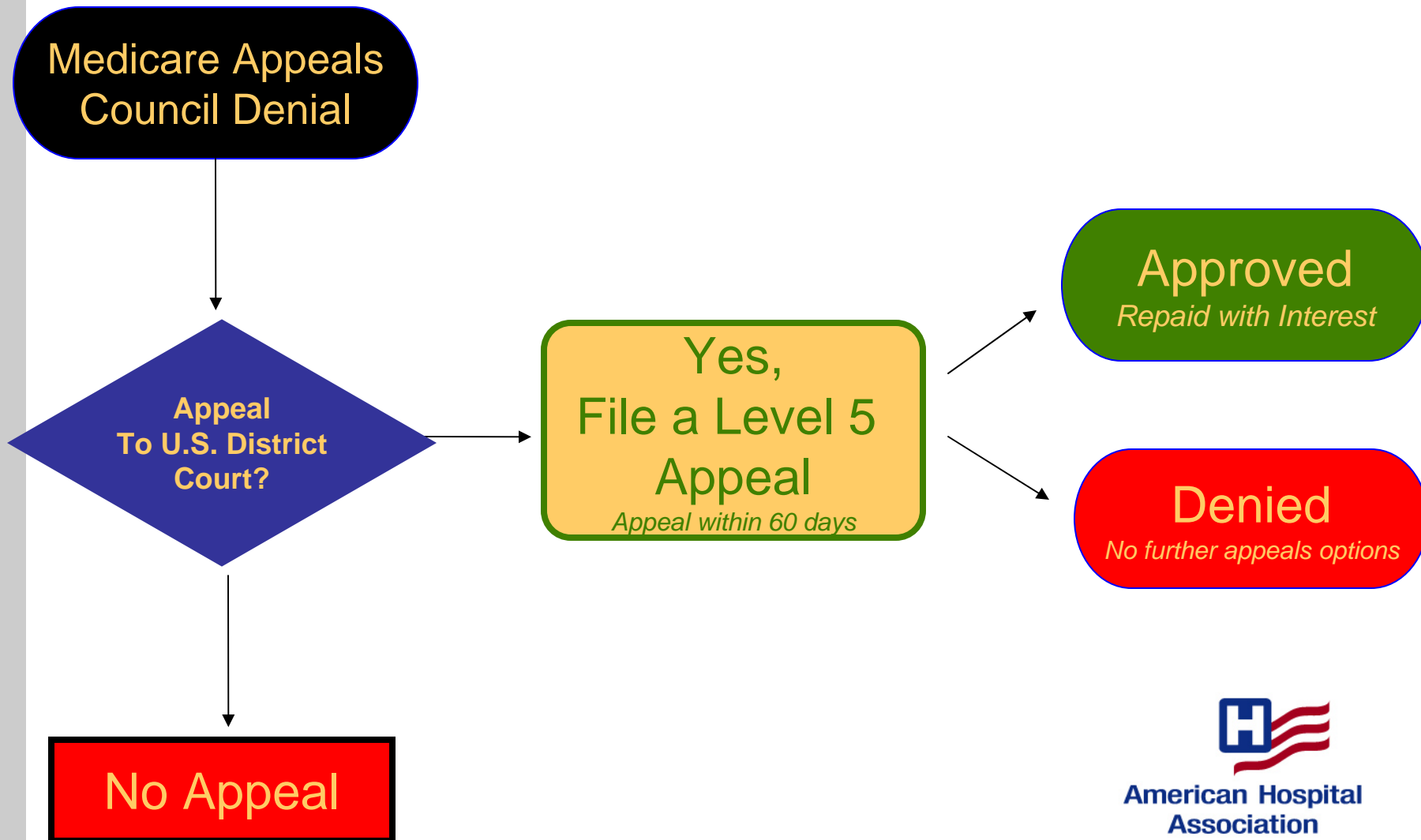


# Level 5: Federal Court Appeal

- Provider may file for review within 60 days of receiving Council decision
- Appeal must be filed in applicable federal district court
- Value of the claim must exceed \$1,220
- Court does not have a specific timeframe in which to make a decision
- Standard for review is “arbitrary and capricious”



# Level 5 Appeals – U.S. District Court



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# Recoupment

- Recoupment process is administered by the primary contractor through:
  - Withholding by the contractor (i.e., offset of current payments)
  - Outright payment by the provider
- New process in place for limiting recoupment during early stages of appeal
  - Shortened timeframe for filing
  - Does not apply to ALJ level or above



# Interest Provisions

- If an overpayment is not repaid within 30 days, interest begins to accrue, even during the “stay” on recoupment
- Current interest rate is 11.375%
- On successful appeals at the ALJ level or above, the provider is entitled to interest from the date of recoupment to date of payment
  - Interest calculated based on full 30-day periods
  - No interest paid on interest, only principal amount



# RACs

- 2 types of review:
  - Automated
  - Complex
- 3-year look-back period
- Demand letter triggers appeal rights
- Right to Discussion with RAC, in addition to rebuttal process
- Follows same appeals process, with same entities



# **Managing Medicare Appeals**

**Operational Considerations to  
Support the Appeal Process**

**Kathy Skrzypczak**

**Asst. Vice President, Corporate Services**

**Martin Memorial Health System**

**Stuart, Florida**



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# Martin Memorial Health System

- Integrated Health System, located on the Central East Coast, Florida
- Operations in 2 counties
- 3,300 Associates
- Two Inpatient Facilities, 344 licensed beds
- 325 Medical Staff Members
- Employ 80 physicians
- 5 Outpatient Diagnostic Testing Centers



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# Martin Memorial Health System

- Health System Net Revenues = \$342M
- Medical Center Net Revenues = \$302M
- 17,500 Inpatient Admissions
- 2,000 Observation Admissions
- Medicare Payer Mix = 68%
- 50% Net Rev. Outpatient Business Lines



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# Considerations for Best Practices

1. Multi-disciplinary Team
2. Control Point for Communications
3. Staffing Considerations
4. Initial Record Requests
5. Electronic Document Management
6. Utilization Review Documentation
7. Claims Tracking Software Solution
8. Assess, Experience, Reassess



# The Claims Denial Team – Multi-disciplinary

Retrospective Claim Reviews and Appeals are relevant to many departments:

- ✓ Asst. VP, Corporate Services
- ✓ Claims Denial, Coordinator
- ✓ Director, Case Management/Utilization Review
- ✓ Utilization Review Project Specialist
- ✓ Supervisor, Hospital Coding
- ✓ Director, Corp. Business Services (Registration, Billing)
- ✓ Finance/Reimbursement Rep.
- ✓ Director, Health Information Management
- ✓ Chief Compliance Officer
- ✓ Clinical Documentation Improvement Specialist



# Control Point for Communications

- **Incoming Mail**

- Distribution Protocols
  - Medical Record Copies
  - Demand Letters
  - Appeal Responses
- Documentation Protocols
  - Entry into Tracking System/Database
  - Document to Patient Accounts
  - Retain copies of communications (file/scan)

- **Outgoing Mail**

- Documentation Protocol
  - Certified Mail
  - Entry in Tracking System/Database
  - Document to Patient Account
  - Retain copies of documents (file/scan)



# Staffing Considerations

## Administrative Support - “Claims Denial Coordinator”

- Monitor timeliness of responses to record requests and appeals
- Monitor appeal outcomes
- Maintains appeal process documentation
- Follow up with outside organizations for claim resolutions
- AKA “The Watch Dog”
- Provides routine updates to Claims Denial Team

## Reviewing Demand Letters and Drafting Appeals

- Availability of Internal Resources & Experience
- Logistics of External Support



# Initial Record Requests – Avoiding Appeals

## Release of Information Staffing

## Use of Document Check Lists

### Additional Information:

- Coding Department – Retrospective Queries are part of the permanent medical record
- Utilization Review Documentation
- Physician Advisor Worksheets are filed in the Medical Record and copied as part of the Contractor Record Request
- Consider a pre-mailing “chart review” process
- Think about the future
  - Retain electronic images of documents sent in response to a record request
  - Avoid accessing paper documentation multiple times



# Electronic Document Management

- Ability for multiple individuals to electronically access copies of:
  - Contractor responses
  - Mail tracking slips
  - Appeal letters
  - Appeal responses
- Possible options for consideration:
  - Stored within claims denial tracking tool
  - Document scanning solution



# Utilization Review Documentation

- Access to admission or time of service utilization review communications
- Retain notes for future use on the Utilization Review Criteria Used to Qualify patients for inpatient admission
  - Document category admission was qualified within
  - Document clinical support of:
    - Severity of Illness (clinical indicators, blood pressure, temperature, etc.)
    - Intensity of Service (rate of IV medications, diagnostic testing, etc.)
- Access to Utilization Review Committee determinations



# Software Tracking Considerations

- Centralized database to be used
  - for numerous payers
  - by multiple concurrent users
- Ability to retain electronic files and scanned documents:
  - Copies of contractor communications,
  - hybrid medical record,
  - copies of postal service tracking, etc.
- Data Fields to support;
  - Financial analysis and financial reporting
  - Data analysis to monitor and identify risk areas for performance improvement initiatives



# Software Tracking Considerations (cont.)

- Designed to support workflow; “target dates for actions” and party assigned to task
- Ability to store coding and utilization review notes/backup
- Internet based; potential to support management of appeals by an external third party
- Retain claim determination outcomes at all levels of appeal; including reason for denial
- Progressive product development – working toward communicating with audit contractors electronically
- Ability to generate AHA RAC Trac data



# Many Unknown Factors....

- Assess organizational resources
- Understand the critical decision points and timeframes in the appeal process
- Develop a process with good internal controls
- Experience that process
- Reassess what is needed to support the Appeal Process within your organization





# QUESTIONS

