

# Socioeconomic tips

## New Medicare appeals process

by the Division of Advocacy and Health Policy

A complete revision of the Medicare appeals process has been made in stages since December 2004. The last step, the revision of the carrier appeals process, took place on January 1, 2006. All claims initially adjudicated by carriers on or after that date will be subject to the new appeals process, as will all requests for the first level of appeal received by carriers after that date. Fiscal intermediary claims adjudicated on or after May 1, 2005, and requests for the first level of appeal received by fiscal intermediaries on or after May 1, 2005, went through the new appeals process.

The Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the changes. Together the two statutes required the following:

- Uniform appeal procedures for both Part A and Part B claims
- Reduced decision-making time frames for most appeal levels
  - The right to raise the case to the next appeal level if it is not decided on time (for cases that are at the second level or higher)
  - New entities, called qualified independent contractors (QIC), to handle the second level of appeal
  - Generally additional evidence presented no later than the second appeal level
  - Transfer of some of the administrative law judges (ALJ) to the U.S. Department of Health and Human Services
  - The correction of minor errors without resorting to the appeals process (implemented in 2004)

There is much that has remained the same about the appeals process, such as the number of levels of appeals, the requirement that each level must be completed in sequence, the time limits for filing an appeal, the types of questions or issues that are subject to appeal, and who may file an appeal. (See

### Around the corner

#### March

Economedix will hold two teleconferences this month. The first, on March 8, will be E&M Coding from an Auditor's Perspective. The second, on March 22, will be Annual Review of the HIPAA Privacy & Security Rules, which includes required yearly training for all physicians and staff. For more information, go to <https://www.YourMedPractice.com/ACS>, or phone 877/401-9655.

#### April

Correct Coding Initiative edits version 12.1 will become effective April 1.

### Figure 1.

#### When can a physician appeal a claim?

Reform of the appeals process does not affect a physician's right to appeal. The following material is provided in the interest of giving a comprehensive picture of the appeals process. Following are instances when a physician can file an appeal:

- The physician has accepted assignment of the claim. Participating physicians have agreed to always accept assignment.
- The physician has not accepted assignment of the claim and the claim is partially or wholly denied as not being medically necessary. This includes instances where the physician has collected payment from the beneficiary but failed to give an advanced beneficiary notice warning that the service might not be covered. The physician may be acting as a physician or a durable medical equipment supplier.
- The beneficiary has died and there is no one else available to appeal.

Remember that a beneficiary always has the right to appeal, unless he or she has assigned his or her appeal rights to the physician.

Figure 1 on page 40 for an explanation of when a physician may file an appeal.)

But there is also much that has changed. Each step in the appeals process (except for federal court review) must be completed in 60 or 90 days. (See Figure 2 on this page for an overview of the new appeals process.) There are specific requirements that the notice of the appeal determination must contain; the most important requirement is that if the appeal deals with the medical necessity of a service, the notice must give an explanation of the medical and scientific rationale for the decision.

### **Redetermination**

- *First level of appeal or redetermination.* The first level of appeal is called a redetermination—rather than “review,” the term used previously—and must be completed in 60 days. The request for a redetermination cannot be made by telephone; it must now be made in writing to the carrier. The requirement that the redetermination be processed by someone who was not involved in the initial determination remains. If the redetermination is adverse to the appellant, the notice of

the redetermination action must explain how to request the next level of appeal and it must also specify any additional documentation that should be furnished at the next level of appeal. (Simple clerical corrections or additions to the original claim, which some carriers required at the first level of appeal, may be handled by “reopening” the claim. That process is discussed later in this article.)

- *Second level of appeal or reconsideration.* The most important changes to this process have been made in the second level of review, which has been termed a “reconsideration.” The first and most important change is that the reconsideration has been moved away from the carrier that initially processed the claim to a QIC. Because the QICs are under an entirely different management structure than the local carriers, there will no longer be grounds for suspecting that a carrier was acting to protect itself rather than giving a truly fair hearing.

The reconsideration, which replaces a carrier’s fair hearing with a paper review, must be completed within 60 days. The dollar amount in controversy threshold of \$100 has been eliminated,

**Figure 2. The revised Medicare appeals process**

<b>Appeal level</b>	<b>Time limit for filing request for appeal</b>	<b>Monetary threshold to be met</b>	<b>Time limit for completing appeal</b>
Redetermination by carrier	120 days from receipt of the notice of initial determination	None	60 days
Reconsideration by qualified independent contractor	180 days from receipt of the notice of redetermination	None	60 days
Administrative law judge hearing	60 days from receipt of the notice of reconsideration	For requests filed in 2006, \$110 or more in controversy. Updated annually.	90 days
Medicare appeals council (MAC) review	60 days from receipt of the notice of ALJ hearing decision	None, but in reality there must be \$110 or more in controversy.	90 days
Federal court review	60 days from receipt of MAC decision or declination of review by MAC	For requests filed in 2006, \$1,090 or more in controversy. Updated annually.	No time limit

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so any denied claim can reach the reconsideration level. Generally any additional evidence must be submitted by the doctor at the reconsideration level.

If the case involves the medical necessity of a service, the reconsideration is carried out by a panel of health care professionals. The Centers for Medicare & Medicaid Services (CMS) makes it clear that for physicians' services, the panel must include at least one physician. However, CMS does not specify the physician's specialty. The QIC can decide not to follow national and local coverage and payment policies in a case but the notice of the reconsideration must provide a rationale for the decision and the case must not set a precedent.

- *Third level of appeal, or ALJ hearing.* A change in the amount in controversy threshold that must be met for the third level of review, an ALJ hearing, has been made and is discussed later in this article.

The ALJs are no longer employed by the Social Security Administration (SSA); they now report to the U.S. Department of Health and Human Services (DHHS). Readers may remember that the Medicare program started out as a part of SSA but was moved to DHHS. Medicare was moved administratively to the Health Care Financing Agency, the predecessor of CMS, in 1978. In 1995, pursuant to legislation, the SSA became an independent agency. The legislation called for moving the ALJs and their workload, which included Medicare cases, from DHHS to the new independent agency. Establishing an ALJ structure under DHHS to handle Medicare cases was not done until the passage of the MMA in 2003. The transfer was actually made in the late summer of 2005.

#### ***Fourth and fifth levels of appeal***

Some very technical changes were made in the fourth level of appeal, the Medicare appeals council (MAC) review. The only change in the fifth level of appeal, the federal court review, is in the amount in controversy threshold (see next section).

#### ***Monetary thresholds for further reviews***

For two steps in the appeals process, there continues to be a monetary threshold that must be met. Through 2005, the amounts had remained

constant. However, starting this year, the amounts must be updated annually to reflect the medical care component of the consumer price index for urban consumers. In 2006, the amount in controversy must be equal to or exceed \$110 for the ALJ hearing and be equal to or exceed \$1,090 for a federal court review. As in the past, appeals may be consolidated if there are common issues of law and fact and similar services were delivered. One common reason for consolidating appeals is to reach the amount in controversy threshold.

#### ***Escalating an appeal to a higher level***

Appellants have the right to escalate a case to an ALJ if a QIC fails to make a timely reconsideration and to the MAC if an ALJ fails to make a timely hearing decision. If a case is escalated to the next level, the ALJ or MAC has 180 days to make a decision. Note that the amounts in controversy thresholds do not apply for cases escalated to an ALJ. If the appellant decides not to escalate the appeal, the case remains with the QIC or MAC to make a decision.

The appellant should carefully consider whether to escalate a case because the requirements are different at each appeal level. For example, escalating a case to the MAC if an ALJ has failed to act in a timely manner may mean that the appellant does not get to present the case in oral argument at an ALJ hearing. (There is no oral presentation as part of the MAC review.)

#### ***Reopenings***

The provision of MMA on reopenings clarified a long-standing area of confusion for the Medicare community when it was implemented in December 2004. Carriers differed in how they treated claims denied for clerical errors or omissions, with some—following the letter of the law—requiring the expense and complexity of submitting a request for a redetermination and others accepting the changes much less formally.

#### ***Conclusion***

Congress had neglected the Medicare appeals process for a long time. Some aspects, such as leaving the ALJs in the SSA, were the result of Congress' failure to take appropriate action when there was an opportunity. Other components, such

*continued on page 49*

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## **SOCIOECONOMIC TIPS, from page 42**

as leaving the second level of appeal at the carrier, were doubtless appropriate at the time of initial enactment of the Medicare program but the weaknesses became apparent over time.

The major changes were made at the second level of appeal, or the reconsideration. Three of the changes are especially noteworthy: moving the second level of appeal out of the carrier, dropping the \$100 amount in controversy requirement, and requiring that at least one physician be present on the QIC panel to make medical necessity decisions for physicians services. Given the volume of reconsiderations that the four QICs will receive, there is a potential for the practitioners within major specialties to see one or more of their own

serving on the panels. Those changes, coupled with a separate management structure for QICs, make it appear that anyone can receive a truly fair reconsideration.

Moving some of the ALJs from the SSA to the DHHS will also serve both the Medicare and Social Security programs well. The ALJs for both programs will be able to specialize in only one complex program and, more importantly, people responsible for the Medicare program will manage the Medicare ALJs.

When members of Congress finally got around to reforming the Medicare appeals process, they did a remarkably good job of correcting all of the shortcomings in a complicated process. Ω