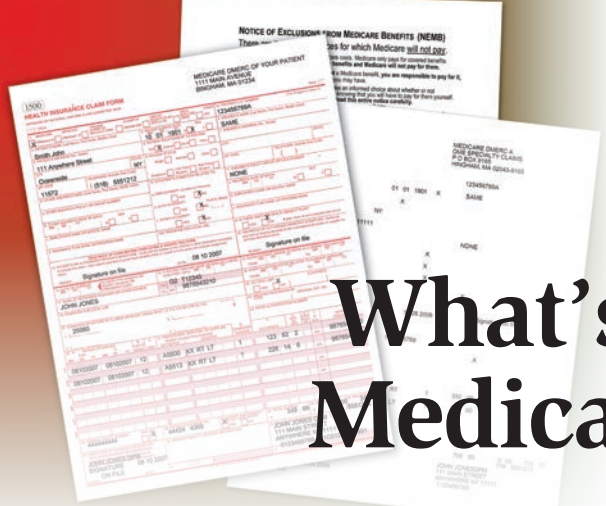

What's New With Medicare Appeals?

Patience and persistence are often rewarded.

BY PAUL KESSELMAN, DPM

Redetermination

The majority of healthcare providers have at one time or another successfully appealed a claim which was originally denied by their Medicare contractor. This first level of appeal with the carrier (Redetermination) is often as far as most providers go when it comes to appealing denied claims. Either this first level of appeal is successful or denied. If this first level of appeal is denied, most providers simply abandon any further appeal rights because the denial contains sufficient information, making a successful higher level of appeal too daunting.

Reconsideration

For those who wish to pursue to the next level of appeal (Reconsideration), the challenges are immense. First, it is often not possible to obtain or present additional documentation to the Reconsideration contractor. Second, the Reconsideration contractor is not the same contractor as the one to whom the claim was sent or denied on the first level of appeal.

The first level of appeal with the carrier (Redetermination) is often as far as most providers go when it comes to appealing denied claims.

The time frame to submit a second appeal is certainly liberal enough (180 days), but it is not often the limiting factor. The limiting factor is either that another healthcare provider's or the prescriber's or supplier's documentation simply does not meet the litmus test(s) required by the LCD.

In the rare cases where more documentation not originally submitted during the first level of appeal is available, the next hurdle is providing this information in an organized and clear fashion to the appellant auditor. Medical documentation often contains conflicts, and EHR templates often are not adequately properly edited, so as to allow the correct story to unfold for the auditor.

A more recent challenge for DMEPOS suppliers is a change in the Reconsideration contractor. C2C Innovative Solutions lost its bid to remain the sole Qualified Indepen-

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dent (Reconsideration) contractor for DME. Maximus, a new entity to DME, is now the sole DME Reconsideration contractor. This is problematic, because Maximus has no real DME experience. Despite congressional initiatives to suspend Maximus' bid award, CMS deemed Maximus the sole DME Reconsideration Contractor. C2C Innovative Solutions will have held its last phone hearing as of September 15, 2019 and will need to complete all its discussions by December 31, 2019. This effectively makes Maximus the sole Reconsideration contractor for all DME.

Your DME EOMB will inform you of your appeal rights and whether the DME MAC (Redetermination) or Maximus (Reconsideration) are the appropriate appeal venues.

ALJ

If you lose a Reconsideration appeal and wish to pursue yet to a third level of appeal, your next step is with an Administrative Law Judge (ALJ). ALJ hearings require a unique skill set and sometimes even legal assistance. To qualify for an ALJ hearing, there must be a minimum $160 outstanding amount owed to either you or the carrier. The $160 can be an outstanding amount from a single claim. In this scenario, that one claim qualifies for a single unique ALJ hearing dedicated to that one claim.

Claims with less than $160 outstanding can nevertheless also be appealed to the ALJ if one can aggregate (lump together) similar claims (therapeutic shoes, or AFOs, etc.) from the same carrier to reach the $160 minimum. If one is applying for an ALJ hearing under the aggregate category, all those claims will be heard simultaneously during one hearing.

There is a liberal time frame from the time you receive your Reconsideration denial until you file an application for an ALJ hearing. Unlike the short Redetermination or Reconsideration timelines for the carriers to respond to your appeal, the ALJ, despite short statutory timeframes, may not schedule your hearing for upwards of 24 months or more. There have been many historic legal challenges attempting to reduce these time frames. However, none of these legal challenges have been met with any real success. CMS has hired additional ALJ hearing officers, but the backlog of cases remains at historically frustrating levels. In a further attempt to reduce hearing backlogs, CMS has offered "instant wins" if one accepts a reduced award on certain types of cases. These "instant wins" are primarily specific to HCPCS coding and dollar value edits of the outstanding claims.

Unlike the short Redetermination or Reconsideration timelines for the carriers to respond to your appeal, the ALJ, despite short statutory timeframes, may not schedule your hearing for upwards of 24 months or more.

Another frustration is that as with Reconsiderations, it is often not possible to either find additional supportive documentation and as is often the case, the ALJ will refuse to accept any documentation not already filed with a lower level (e.g., Reconsideration) appeal. ALJ hearings are often held remotely and may be video-conferenced, requiring you to go to a facility where the ALJ officer may not even be present. As with any other court proceeding, you (and a witness) will be provided an opportunity to provide testimony on the merits of your case and it will be recorded. The ALJ will often also ask you direct questions in addition to your testimony. Thus, you must be very familiar with your documentation, Medicare regulations, etc. An ALJ decision is statutorily required within 90 days of the hearing, but again, due to the backlog of cases, that time frame is rarely met. One may then file an application with the Medicare Appeals Council.

The good news for both Reconsideration and especially with ALJ hearings, is that there is an overwhelming number of successful overturns of previous lower level claim denials.

The good news for both Reconsideration and especially with ALJ hearings, is that there is an overwhelming number of successful overturns of previous lower level claim denials. Thus, the work and the wait may be worthwhile. ALJ hearing officers, unlike Redetermination and Reconsideration officers, are not bound by CMS policy. ALJ hearing officers will review the LCD, Policy Articles and Supplementary Instruction Articles (SIA), but are not legally required to follow those policies.

If one can make a persuasive, compelling, compassionate argument, devoid of emotion, based on the medical merits of your case, one often can successfully negotiate the ALJ's long and arduous process. As noted previously, the bad news is the long wait for a hearing date.

Redeterminations, Reconsiderations, and ALJ hearings are available for initial claim denials as well as on post-payment recoupment audits. This includes post-payment attempts by the DME MAC, QIC, CERT

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and RAC. There is, however, one huge catch, particularly on the side of post-payment recoupment. Usury interest rates often apply to post-payment recoupment audits, and they apply from the time of the recoupment decision. Thus, if a provider loses an ALJ hearing on a post-payment audit, it is possible to not only have to pay back the principle paid amount, but 30 or more months of interest on the paid amount as well. Of course, if you win an ALJ hearing, the government will not pay you usury interest (if any at all) on the money owed to your practice.

Unlike other court cases, the successful outcome of one ALJ hearing does not set precedent for future cases. Thus, you cannot use the successful outcome of one ALJ hearing of yours or a colleague's as precedent-setting on future ALJ hearings.

Overall, one should carefully consider the toll of continuing the appeals process for claims which were denied, no matter the level. Cutting your losses, removing the emotional attachment to the issue, and deciding not to appeal is what Medicare and other third party payers often count on. Each claim denial should be reviewed in order to determine the merits of continuing to pursue higher levels for appeal. Unless you are almost 100% certain that you are correct, from a practical perspective, it is often not worth continuing to appeal claims beyond the carrier. The hourly wages you pay your staff, or an attorney, or the opportunity costs of spending time away from other revenue-generating practices, can quickly eat up any revenue you might generate in winning an appeal. In other words, winning is not all it's cracked up to be!

Losing a first level of appeal can also be a win for your practice, particularly if you view those losses with the proper perspective. Taking the lessons learned from a lost appeal (or denied claim) and putting them into action can result in winning future appeals. Equally important, losing may provide valuable lessons to reduce future pre-payment denials or future post-payment recoupment.

Remember, success is often based on failures of the past! **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.