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Navigating the Medicare Appeals Process: Strategies for Dealing with Denied Hospice Claims

Strategies for Dealing with Denied Hospice Claims

Nothing comes easy when dealing with Medicare, and appealing denied claims is no exception. Successfully appealing Medicare denials requires time, organization and an understanding of Medicare regulations; however, it generally does not require hiring a lawyer, at least at the first few levels of appeal. By understanding the procedures for appealing denied claims, as well as the content to include in the appeal request, hospices can take charge of the appeals process and obtain payment for wrongly denied claims.

Overview of the Medicare Appeals Process

Congress passed legislation in 2000 and 2003 that significantly modified the Medicare appeals process, and the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule on March 8, 2005 that implemented those changes. CMS has stated it will finalize the rule by March 1, 2009. Currently, there are five levels to the Medicare appeals process: (1) redetermination, (2) reconsideration, (3) administrative law judge (ALJ) hearing, (4) Medicare Appeals Council review, and (5) judicial review by a federal court. If the hospice receives a denial at one level, it can proceed to the next, until it receives a favorable decision, or a federal court finds against it.

The multiple levels of administrative review allow hospices several opportunities to make their cases in front of different decision makers, but also means that the hospice must be aware of the varying rules that apply at each level of appeal. The hospice should be aware of the following limitations, which vary depending on the level of appeal: (1) the time limit for filing the appeal, (2) the documentation that must be presented with the appeal, and (3) whether there is a minimum amount of money that must be at stake (called the "amount in controversy") to file the appeal. The following summary provides an overview of the important considerations at each level, and shares some of our practical experience with the process. For additional information, we recommend reviewing materials about the appeals process provided on the Web site of your regional home health and hospice intermediary (RHHI), as well as the regulations found at 42 C.F.R. §§ 405.900 - 405.1140.

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Level 1: Redetermination

At the redetermination level, the RHHI will conduct an independent review of the initial claim denial.[1] The hospice must submit a request for redetermination within 120 days of receiving the claim denial. The request should be made on Form CMS-20027,[2] or on another document that contains the following information: (1) the beneficiary's name, (2) the Medicare health insurance claim number, (3) the specific services for which the redetermination is being requested and the specific dates of service, and (4) the name and signature of the appealing party.3 The request should include any additional documentation explaining why the hospice disagrees with the RHHI's initial denial.[4] The RHHI must issue a decision within 60 days of receiving the request for redetermination.[5]

Hospices have been and can be successful at reversing claim denials at the redetermination level. In its redetermination request, the hospice can "paint the picture" of the patient's hospice eligibility by persuasively presenting the facts which support eligibility. Also, if the RHHI overlooked key documentation in its initial denial, the redetermination request allows hospices the opportunity to explain the documentation and where it can be found in the medical record. However, even if the hospice convinces the RHHI that it was wrong to deny a claim for one reason, the RHHI may deny the claim for a new reason at the redetermination level.

Level 2: Reconsideration

If the hospice wishes to appeal a redetermination denial, it must file a request for reconsideration within 180 days of receiving notice of the redetermination denial.[6] The request should be submitted on Form CMS-20033,[7] or on a document that contains the following information: (1) the beneficiary's name, (2) the Medicare health insurance claim number, (3) the specific services for which the redetermination is being requested and the specific dates of service, (4) the name and signature of the party, and (5) the name of the RHHI that made the redetermination decision.[8]

The reconsideration request is reviewed by a separate Medicare contractor, known as a Qualified Independent Contractor (QIC). For clinical denials, the QIC's panel must include physicians or other appropriate health care professionals.[9] In general, the QIC must issue a decision within 60 days of receiving the reconsideration request.[10]

In our experience, it has been extremely rare for the QIC to overturn the RHHI's

decision. Although the QIC generally acts as a "rubber stamp," the hospice should carefully consider the evidence it presents to the QIC because the hospice will not be able to present evidence in future appeals that was not presented to the QIC, unless there was "good cause" for omitting the evidence in the reconsideration request.[11]

Level 3: Administrative Law Judge (ALJ) Hearing

ALJ hearings are generally conducted either by video-teleconference or by telephone, although in rare circumstances they may be conducted in person. Alternatively, the parties may waive the right to a hearing, and the ALJ may make a decision on the written record.[12] Although CMS and/or the RHHI and QIC may participate in the hearing, in practice it is very unusual for them to do so.

The hospice must request an ALJ hearing within 60 days of receiving a reconsideration denial from the QIC.[13] The request can be made on Form CMS-20034A/B,[14] or in a document that contains all of the following information: (1) the beneficiary's name, address, and Medicare health insurance claim number; (2) the appellant's name and address; (3) the name and address of designated representatives, if any; (4) the document control number assigned by the QIC, if any; (5) the dates of services; (6) the reasons the appellant disagrees with the QIC; and (7) a statement of any additional evidence to be submitted and the date it will be submitted.[15] For requests made in 2008, the amount in controversy must be at least $120.[16]

The ALJ will render a decision within 90 days of receiving the hearing request. The hospice should be sure to send a copy of the hearing request to the patient whose claim was denied, or else the ALJ's 90-day deadline for issuing a decision will be extended.[17]

We have found ALJs to be more receptive to hospice arguments than QICs or RHHIs, in part because the ALJs are generally more willing to depart from the specific criteria of local coverage determinations. While the idea of appearing before an ALJ, even over the telephone, can be a bit intimidating, in practice ALJ hearings are not nearly as formal as court proceedings, and can generally be managed successfully by well-prepared hospices without the assistance of legal counsel.

Level 4: Medicare Appeals Council Review

The hospice (and, in some cases, CMS or its contractors) may appeal the case to

the Medicare Appeals Council (Appeals Council) if the request for review is filed within 60 days of receiving the ALJ's decision.[18] Although parties can request to appear before the Appeals Council for oral arguments, the Appeals Council generally makes its decision based on the written record and any briefs filed by the parties. The hospice may wish to retain an attorney at this point, who can help the hospice prepare a persuasive brief, and will then be well-versed in the case if appeal to federal court is necessary.

The request for review must identify the parts of the ALJ decision with which the party disagrees, and the Appeals Council will limit its review to those issues.[19] The request can be made on Form DAB-101, or another document that contains the following information: (1) the beneficiary's name and Medicare health insurance claim number; (2) the specific dates of service; (3) the date of the ALJ's final action; (4) the name and signature of the appealing party; and (5) any other information CMS may decide.[21] The Appeals Council will make its decision within 90 days of receiving the request for review.[22]

Level 5: Judicial Review

If a hospice wants to appeal the Medicare Appeals Council's decision, it must file an action in federal district court within 60 days of receiving notice of the decision.[23] As of 2008, there must be at least $1,180 in controversy to appeal the case to federal court. The defendant in the case will be the Secretary of the Department of Health and Human Services (HHS), and any findings of fact by the HHS Secretary are conclusive if they are supported by substantial evidence.[24]

Although hospices may be able to manage the other levels of administrative appeals on their own, they should retain an attorney if they decide to appeal the case to federal court. Because court proceedings can be very expensive, it will only make sense to appeal cases to this level when there is a significant amount of money at stake.

Strategies for Successful Appeals

The following tips focus on appeals at the redetermination, reconsideration and ALJ level, which are the most common types of appeals that hospices will undertake.

1. **Draft a Persuasive Cover Letter**. Although not required, the cover letter provides the opportunity to present the hospice's arguments of why the patient was eligible for hospice care. In the cover letter, the hospice can set

forth the key facts, and argue persuasively to show that those facts met the legal standard for eligibility. The cover letter also allows the hospice the opportunity to respond directly to the contractor's reason for denial. For example, if the RHHI or QIC asserted that there was no evidence of recorded weight loss, the hospice can explain that there were other indications of significant weight loss, such as loose-fitting clothing, or other comorbidities that supported the terminal prognosis. Developing an effective letter at the redetermination level increases the hospice's chance of success early in the appeals process. Furthermore, the same letter can be easily modified to use for the reconsideration request and the request for an ALJ hearing as well. ALJs have also been requesting that appellants file "written statements," and the cover letter can be used to satisfy this requirement as well.

2. **Stay Organized**. It can be difficult to keep track of all of the deadlines for each level of appeal, particularly if you are dealing with more than one denial. Make sure that your appeal is not time-barred by developing a system to monitor approaching deadlines. For purposes of complying with filing deadlines, note that in general, it will be presumed that the hospice received a denial five days after the date of the denial, unless there is evidence to the contrary, and appeal requests will be considered filed on the date they are received by the appropriate entity.[25]
3. **Consider Hiring an Outside Clinical Consultant**. Outside clinical consultants can bring a voice of objectivity to claims that were denied for clinical reasons. Clinical consultants can write a letter in support of eligibility if the hospice appeals a denial, but, just as importantly, they can let the hospice know when they believe that the documentation does not objectively support eligibility.
4. **How to Address Local Coverage Determinations**. The RHHIs have developed Local Coverage Determinations (LCDs) to describe the clinical conditions in which it will consider the patient to have a six-month life expectancy. For the purposes of Medicare appeals, there are several important things to remember about the LCDs. First, the LCDs are not the same thing as the legal requirements for hospice eligibility. QICs, ALJs and the Appeals Council are not bound by LCDs, but they will give them substantial deference if they are applicable.[26] Second, the LCDs are not always precise. Some of the standards may be imprecise and subject to interpretation. Finally, most of the LCDs include disclaimers that patients may still be eligible for hospice care, even if they do not meet all of the elements of the LCD, if there are other reliable indicators of a terminal

condition. In general, the cover letter should address the LCDs, and should discuss why the patient met the LCD, or, if the patient did not meet every element, what other factors supported a terminal prognosis. A hospice should not feel that it cannot appeal a case because the patient did not meet every element of an LCD.

5. **Make It Easy for the Decision Maker to Find in Your Favor**. All of the contractors are facing a backload of cases, and it is possible that the key facts in your case will get lost in the shuffle if you do not point them out clearly to the reviewer. Make it easy for the reviewer by organizing the medical record in a coherent fashion and making key documentation easy to find. Denials can sometimes result from the contractor failing to see a document in the medical record. We have seen cases where the contractor denied a claim for lack of a timely certification of terminal illness, but the contractor had overlooked documentation of a verbal certification. Attaching key documentation as a separate exhibit, or pointing out where in the medical record it can be found, can help overcome these problems.
6. **Learn from the Process**. Although appealing a claim denial certainly is not fun, it can be educational. If a claim was denied because the documentation did not support eligibility, try to understand what part of the documentation was perceived to be insufficient and develop strategies to address the issue. If you find yourself subject to a number of technical denials, reevaluate your certification processes and notice of election forms.

Reinhart's Appeals Toolkit

Although attorneys can be helpful in crafting effective and persuasive appeals, their fees may end up being more than the amount of the denied claims. Reinhart is in the process of developing a toolkit to help hospices navigate the first three levels of appeal on their own. The toolkit will provide an extensive review of the practical and strategic considerations facing hospices in the appeals process, such as whether to consolidate multiple appeals or what to do if a contractor fails to make its decision in the required timeframe. The toolkit will also include sample cover letters, forms, "to-do" lists for each level of appeal, and materials that will help hospices prepare for ALJ hearings. For early purchasers, we will also be offering the opportunity to participate in an audio conference that focuses on strategies for the ALJ hearing.

These materials will provide a cost-effective way for hospices to be well-informed and confident when challenging wrongfully denied claims. With the right tools,

preparation, and organization, hospices can successfully manage the redetermination, reconsideration, and ALJ process with little or no assistance from legal counsel.

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[1] 42 C.F.R. § 405.942(a) (2007).
[2] This form can be accessed online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20027.pdf.
[3] 42 C.F.R. § 405.944(b).
[4] 42 C.F.R. § 405.946.
[5] 42 C.F.R. § 405.950(a).
[6] 42 C.F.R. § 405.962(a).
[7] This form can be accessed online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf.
[8] 42 C.F.R. § 405.964(b).
[9] 42 C.F.R. § 405.968(a).
[10] 42 C.F.R. § 405.970.
[11] 42 C.F.R. § 405.966(a)(2).
[12] 42 C.F.R. § 405.1000(e).
[13] 42 C.F.R. § 405.1014(b)(1).
[14] This form can be accessed online at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20034AB.pdf.
[15] 42 C.F.R. § 405.1014(a).
[16] The amount in controversy may increase based on a set formula.
[17] 42 C.F.R. § 405.1014(b)(2).
[18] 42 C.F.R. § 405.1102(a)(1).
[19] 42 C.F.R. § 405.1112(b)-(c).
[21] 42 C.F.R. § 405.1112(a).
[22] 42 C.F.R. § 405.1100(c).
[23] 42 C.F.R. § 405.1130.
[24] 42 C.F.R. § 405.1136.
[25] See 42 C.F.R. §§ 405.942(a); 405.962(a); 405.1002(a); 405.1102(a).
[26] 42 C.F.R. §§ 405.968(b)(2); 405.1062(a).

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