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Reimbursement, Billing, ADRS and Claim Appeals – Hospice Appeals

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I. The Importance of Understanding the Medicare Appeals Process

Given the current emphasis on additional development requests ("ADRs"), whether beneficiary edits, or probe edits, it is particularly important to understand the hospice appeals process. This process, due to the provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, ("MMA") is undergoing some changes that are also important to understand.

When confronted with an ADR, it is important to include as much documentation in support of eligibility as is possible. Most of the probe edits are based on eligibility criteria and the six month prognosis, but others focus on level of care, either general inpatient or continuous care. In order to justify the eligibility of the patient or the level of care, it is important that documentation be clear. CMS's instructions to fiscal intermediaries for hospices, known as Regional Hospice & Home Health Intermediaries ("RHHIs"), is that they must deny claims when eligibility is not demonstrated in the documentation, and it is important for hospices to "paint the picture" to clearly establish eligibility.

According to consultant Joy Barry, RN, M.Ed., Vice President of Weatherbee Resources, Inc., a national hospice consulting firm, it is important that documentation submitted to RHHIs:

> "include sufficient evidence of why the patient is considered terminal upon admission to hospice; continuously and consistently support the terminal prognosis; contain objective evidence that the patient met the UniPolicy or LMRP/LCD and contain the certificate of terminal illness or recertification pertinent to the dates of service in question."

Ms. Barry further states that documentation submitted to RHHIs should contain vital signs, weights or body mass measurements, meal percentages, lab values and/or other objective data; provide a picture of the patient's status that fully

supports the terminal prognosis rather than a "snapshot in time"; not contain improper corrections such as write-overs, cross outs and/or date changes; include an individualized Plan of Care and adequately reflect recertification discussions at IDT meetings.

IDT documentation should not contain the following phrases (unless there is clarification and/or supportive objective evidence):

"Stable"
"No change"
"Doing well"
“Eating well"
"Slow, progressive decline"
"Appears to be losing weight"

Hospices are encouraged to document carefully, and to obtain training and expert consultation for hospice staff as appropriate. In preparing appeals, hospices are encouraged to prepare a summary letter and to highlight the documentation in the clinical record to establish eligibility. It is important to remember that hospice providers, in responding to an ADR, are not limited to the claim period in question and may submit documentation outside of the claim period to establish eligibility and support the terminal prognosis. The following is a summary of the Medicare appeal process and revisions that will be required by the MMA.

II. The Current Medicare Part A Appeal Process

1. **Request for Reconsideration**. The Medicare Part A "request for reconsideration" procedure entitles an individual who is a party to a payment determination, and who is dissatisfied with the initial determination, to request a reconsideration of such determination. The request for reconsideration must be in writing and signed, and must include a statement of dissatisfaction with the initial determination. Providers may appeal, if the ultimate liability rests with them, or if the beneficiary (patient) so authorizes. The RHHI websites include appeal forms, which may be used; use of these specific forms is not required however. The request for reconsideration must be filed within 120 days after the RHHI provides notice of the initial determination.
2. **Right to a Hearing Before an Administrative Law Judge ("ALJ")**. A

hospice provider has a right to a hearing regarding any initial determination if the following criteria are met: (i) the initial determination has been reconsidered; (ii) the requestor was a party to the reconsidered determination; (iii) the requestor or his or her representative has filed a written request for a hearing in accordance with 42 C.F.R. 405.722; and (iv) the amount in controversy is $100 or more. A request for an ALJ hearing must be made within 60 days of receipt of the reconsideration determination.

3. **Appeal to the Appeals Council**. A party that is dissatisfied with an ALJ hearing decision or with the dismissal of a hearing request may request review by the Appeals Council. The Appeals Council will review a case if (i) there is an abuse of discretion by the ALJ; (ii) there is an error of law; (iii) the actions, findings, or conclusions of the ALJ are not supported by substantial evidence; or (iv) there is a broad policy or procedural issue that may affect the general public interest. Any request for Appeals Council review must be filed within 60 days of receipt of notice of the ALJ decision or dismissal.
4. **Court Review**. A party may obtain a court review of an Appeals Council decision or an ALJ decision (if the Appeals Council does not review the ALJ decision) if the amount in controversy is $1,000 or more. A request for court review may be filed in any district court of the United States.

III. Appeal Revisions

1. **Transfer of ALJ Responsibility to the Department of Health and Human Services**. The MMA calls for the transfer of responsibility for Medicare ALJ appeals from the Social Security Administration to the Department of Health and Human Services ("DHHS") no earlier than July 1, 2005 but no later than October 1, 2005. This could be one of the most significant changes in the appeals process, since currently the percentage of appeals overturned at the SSA is very high. The Office of the Inspector General in fact has complained about this high reversal rate and has been an advocate for the transfer of these duties to DHHS. While there is some concern about the independent process of the ALJs under DHHS, the law does require that the administrative law judges be separate from CMS and report directly to the Secretary of DHHS.
2. **Expedited Access to Judicial Review**. The MMA creates a new process whereby beneficiaries, providers and suppliers may have expedited access to judicial review in certain appeals. Expedited review is available when it is determined that the Appeals Council lacks authority to decide a question of

law or regulation relevant to the case; and there is no material issue of fact in dispute.

3. **Revisions to the Appeals Process**. A significant change in the law, effective October 1, 2004, is that providers and suppliers bringing appeals for Medicare claims will no longer be permitted to introduce new evidence at the ALJ level of review, unless they can show good cause as to why the evidence was not introduced at an earlier level of review. This is a particularly important change to be aware of, as it will become critical to provide all evidence at the outset. Up until now, providers have been permitted to introduce new evidence at any point in the process and this new restriction is expected to create a burden on providers introducing clinical evidence. In the event of major claims disputes, providers are encouraged to carefully review the appeal procedures.
   Fiscal intermediaries and carriers are required to provide written notice of initial determinations and redeterminations, including the reason for the denial and whether a local medical review policy (LMRP) or local coverage determination (LCD) was applied. At the first level appeal, which will now be known as the "redetermination", there must be a specific reason for the denial, including clinical or scientific evidence. The notices must be written in a manner calculated to be understood by the beneficiary. This is useful, since current denials are often very vague and confusing, not only to patients but to providers.
   Qualified independent contractors ("QICs") will handle the second appeal level. These QIC reviewers must be "independent" and must be clinical professionals with certain required expertise germane to claim in question.
4. **Prior Determination**. A significant change allows a physician or a Medicare beneficiary to obtain a determination from the fiscal intermediary before a service is provided. While the process applies to participating physicians and beneficiaries, it may have some applicability in the case of hospice if there is uncertainty about the six month prognosis.
5. **Miscellaneous Provisions of Possible Assistance to Hospices**. In addition to the law changes listed above, hospices should be aware that there are a number of provisions relating to provider education. For example, beginning October 1, 2004, all fiscal intermediaries must provide tailored education or training, including technical assistance, to small providers defined as those with fewer than 25 full-time equivalent employees. On that same date, CMS and the fiscal intermediaries are required to include "frequently asked questions" on their websites. The MMA also directs CMS to appoint a Medicare Beneficiary Ombudsman to assist Medicare

beneficiaries with requests for information and complaints.

IV. Conclusion

The Medicare Hospice Benefit is increasing in terms of utilization and claims dollars. Fiscal intermediaries can be expected to edit a certain percentage of these claims and it is important in terms of protecting beneficiaries' rights to hospice care and the fiscal stability of their organizations, that hospices understand the regulations, the need for careful documentation and the appeals process itself. Hospices should be prepared to advocate for coverage for eligible patients and to back up that advocacy with a clear understanding of regulations and sound documentation.