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Decisions, decisions, decisions: Appealing denials, addressing interest, and making a case

Denied claims got you down? An upper-level appeal may be the answer.

Of course, organizations must make thoughtful decisions, on a case-by-case basis, when it comes to appealing claim denials.

Giving claim denials individualized attention allows the hospital to learn something even if it decides not to appeal, says **Michael Taylor, MD**, vice president of clinical operations at Executive Health Resources (EHR) in Newtown Square, PA. “If they conclude the denial is appropriate, they should correct their processes so that the mistake does not happen again.”

However, most providers will choose to appeal at one point or another, and there are a host of decisions influencing that choice. You need a strong RAC team leader to make these decisions, but that leader absolutely must have access to a multidisciplinary team. Without help, the RAC team leader will struggle to effectively appeal and meet the tight time frame necessary to prevent recoupment, says Taylor. You may want to involve compliance staff members, legal counsel, members of the financial team, HIM, and a physician to help determine the appropriateness of an appeal. Considering the number of HIM directors and managers who lead and participate in RAC teams, understanding the appeals process and the decisions involved is paramount.

Take interest in interest

First, providers need to consider recoupment and interest. “This is a big decision for a hospital going ahead with an appeal. Should they elect to allow recoupment by the Medicare Administrative Contractor (MAC), or should they file their appeal quickly to avoid recoupment?” Taylor says. Hospitals also have a third option: making a voluntary repayment, he adds.

The decision to appeal has financial implications. If the hospital prevents recoupment but ultimately loses

the appeal, it could be liable for interest. However, if the hospital allows the recoupment on day 41 after receiving the demand letter and then wins at the Administrative Law Judge (ALJ) level (i.e., the third level of appeal) or higher, the hospital may be entitled to the interest payments.

The fact that hospitals don’t receive interest on voluntary repayments overturned at the ALJ level came as a surprise to **Jennifer Jones, MBA, RHIA, CCS, CCS-P**, director of revenue recovery at INTEGRIS Health in Oklahoma.

“If you choose to refund your MAC to avoid paying interest, even if you pursue an appeal, Medicare considers that a voluntary repayment,” Jones explains. “So if you overturned the case at the ALJ level or higher, Medicare will not refund you with interest.”

And considering that getting a decision at the ALJ level can take time—Jones estimates 12 months—the interest at 11% can be a significant amount of money.

But deciding how to handle the financial side of the appeals will vary from case to case and provider to provider.

“You have to consider the strength of the individual case as well as financial considerations, such as cash flow,” Taylor explains. “A hospital that has little money available or high borrowing costs may not be as easily able to allow recoupment because they may be in a tighter financial situation.”

Jones notes, however, that if an inpatient claim is denied, hospitals can’t simply bill the claim as an outpatient bill but instead may only bill for a few ancillary services, and then only in certain cases—and those don’t usually add up to more than a few hundred dollars.

“Unfortunately, if you do not appeal, you will lose most of the Medicare reimbursement,” she says. She recently heard a colleague explain it as, “If you run a red light, you get the death penalty.”

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"This is frustrating for providers. Your intentions are good and you try to do the right thing. But if you get it wrong, you lose almost everything," Jones says.

Handle first- and second-level appeals

When a hospital believes a RAC denial is in error, it can use the discussion period as a chance to prevent the need for the formal appeals process, Taylor explains.

The five levels of the Medicare claims appeal process are:

1. Redetermination by the MAC
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. ALJ hearing
4. Medicare Appeals Council review
5. Judicial review in U.S. District Court

(You can view additional detail on all five levels of appeal, including time frames and other guidelines and processes, on the CMS website at www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.)

Taylor notes that at the first level of appeal, redetermination, the MAC adjudicates the appeal through the use of screening criteria (e.g., InterQual or Milliman) and clinical judgment (usually by a nurse or therapist). One positive aspect of the first level of appeal is that even if the denial is upheld, providers may get a bit more information regarding the reasoning behind the denial, Jones says.

At the second level, the QIC (which for Medicare Part A is Maximus Federal Services), inpatient hospital medical necessity reviews are performed by a physician.

Of particular note to HIM staff members is that providers must submit all documentation and evidence by the second level of appeal. Without a showing of good cause for introducing additional evidence, an ALJ may bar evidence introduced after the second level, which could decrease the chance of a successful appeal, says Taylor.

The overturn rates for the first two levels of appeal are relatively low. As of presstime, only 17% of QIC judgments

in the second quarter of 2011 had been favorable or partially favorable to the provider. (For the latest statistics, visit www.q2a.com/Statistics.aspx.)

As such, providers shouldn't necessarily get discouraged if the denial is upheld at these levels, Jones explains. "If you truly think you have a good case, don't get discouraged if you feel like it has been upheld at level one and level two," she says. "In our experience, the greatest success is at level three, where you actually get to speak to a judge and discuss the merits of the case."

To the ALJ and beyond

The third level of appeal involves a hearing with an ALJ, all of whom are accomplished attorneys who have at least seven years of experience or training and have passed a merit-based exam, according to Taylor. They spend a lot more time on each case, and the hearing is typically conducted via phone or videoconference.

"They are an unbiased group who are trying to take a fair look at the case and look at all the evidence," Taylor says.

Although he has heard criticisms that the ALJs don't have a clinical background and therefore can't understand the medicine involved in the appeal, Taylor disagrees. His experience has shown that they really are looking for evidence.

The overturn rate at the ALJ level is significantly higher than at the first two levels of appeal. At EHR, where cases are carefully reviewed for appealability, the success rate is over 90%.

Taylor believes the turnover rate is much better at the ALJ level because providers have a better opportunity to explain their case.

"I think the difference is that the ALJs look at all the evidence, they are generally well informed, spend more time on the cases, and they get to actually hear the provider's words," he says. "And that's a big difference than earlier on in the process where it's just a written letter."

The ALJs are also more independent because they answer directly to HHS.

Providers unaccustomed to ALJ appeals may want to note the following logistical information:

- ▶ The amount of time it takes from when you send in the request for an ALJ hearing to when the hearing is scheduled may vary based on which Office of Medicare Hearings and Appeals you're scheduling with; ALJs can get quite backed up. "We have had requests for a hearing within a few days. That's rare. Usually you have a few weeks to prepare," Taylor says. Jones agrees that it can take a long time to get this far into the appeals process. She estimates 12–14 months. "The wait is painful," she admits.
- ▶ The ALJ may decide on the case without even holding a hearing if the evidence makes it abundantly clear what the decision should be, Taylor says. "If the provider has assembled a really great case at the lower levels from their appeal letters and the evidence of the chart, [the ALJ] may issue a favorable decision just based on that record."
- ▶ The hearings are intended to be nonadversarial, according to Taylor. In the past, the contractor who denied the claim was not represented at the hearing; however, this seems to be changing, he says. "More recently we have seen contractors, medical directors from contractors, and QIC representatives—whether physicians or attorneys—participating in the hearings to present their side of the case," Taylor says. He suspects this will become increasingly common in the future.
- ▶ Hearings can last from a few minutes to an hour or more, Taylor says. Be prepared for either extreme.

"When you've seen one ALJ hearing, you've seen one ALJ hearing," he says. Don't get lulled into a sense of security if you've been through a few similar hearings—that's not the best way to ensure you set forth the strongest case. Some judges will let you present a narrative, for example, while others will pepper you with detailed questions, Taylor explains. "Be prepared to go through the case in detail," he says. "You should know the record inside and out. You should know where the admission orders are and your explanation for why you disagree with the denial."

- ▶ Providers generally receive the judge's decision in the mail a few weeks after the hearing. The letter discusses, in detail, the legal basis for the decision and the analysis of the case, Taylor says. It will also state whether the decision was favorable, partially favorable, or unfavorable. If the denial is overturned, the letter instructs the MAC on what to do next, such as refunding some or all of the disputed funds.
- ▶ Extensive preparation is crucial. "When appropriate, providers need to prepare a strong clinical argument as well as a strong regulatory argument," Taylor explains. A provider needs to know the technical requirements of the case and consider all aspects of it that could be challenged, he says. Denial for a lack of an admission order requires a different argument than a challenge to a procedure based on medical necessity. "Providers must have a detailed evaluation of all these nuances, otherwise they are not going to address the right issue in their appeal. That may sound basic, but it is very important," Taylor says.

It is pretty unusual for Jones and her colleagues to consider appealing beyond the ALJ level. Among INTEGRIS Health System's dozen hospitals, she has taken three or four cases to level four. (Decisions are still pending.)

INTEGRIS has a very high overturn rate at the ALJ, so escalating an appeal beyond that level rarely becomes an issue. "So routinely we don't take things to the fourth level, but it's because we don't have to," says Jones.

And, of course, that's a very good thing. ■

Questions? Comments? Ideas?

**Contact Senior Managing Editor
Andrea Kraynak, CPC**

Telephone 781/639-1872, Ext. 3801

E-mail akraynak@hcpro.com