

New Medicare Appeals Rules By G. Christopher Kelly

Recently, there was an announcement of a drastic change in the way all medical service providers will appeal denied Medicare claims. On March 8, 2005, the Department of Health and Human Services (DHHS) and the Center for Medicare and Medicaid Services (CMS) published an Interim Final Rule in the Federal Register regarding the Medicare Program entitled “Changes to the Medicare Claims Appeal Procedures”. Some of the provisions contained in this Rule come from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”).

The Rule as published is 80 pages long, and contains many changes, both large and small, to the Medicare appeals rules. The major changes are to the structure of the appeals process, including the following. Under the new Rule, there will be a uniform appeals process for all Part A and B claims; no longer will the appeals process vary between Carriers. As part of this new process, a new position will be created, a “Qualified Independent Contractor” (QIC), who will conduct reconsiderations of claim denials made by fiscal intermediaries, carriers, and quality improvement organizations. There will only be 4 of these “QIC’s” nationwide. There will also be a QIC appeals panel, made up of medical professionals, that will reconsider cases involving medical necessity issues. The time frame for making decisions on administrative appeals has also dramatically decreased; a process which could previously take more than three years must now be completed in no more than 300 days. And finally, if the carrier or fiscal intermediary denies your claim and that denial is upheld by the QIC or QIC appeals panel, then you can still appeal the denial to an Administrative Law Judge (ALJ), but the change there is that the ALJ will no longer be a Social Security ALJ, but an HHS ALJ whose sole responsibility will be Medicare appeals.

There are also many other, less noticeable changes. However even some of these smaller details may greatly effect how appeals are filed and handled by medical service providers such as ambulance services. One such change is that you must present all evidence (medical records, etc.) that supports your appeal at or before the QIC hearing level. You will no longer generally be able to bring in new evidence at the ALJ level. This and other changes will force medical professionals to be very thorough when filing appeals for their denied claims.

There is good news and bad news in between the lines of this new Rule. The good news includes the reduction in time that it takes for an appeal to be decided. In an industry where receipt of Medicare payments is often necessary to keep operations up and running, a shortened appeal process will be a welcomed change. However the bad news includes the fact that there are new hoops that you must jump through to make sure that you win your appeal. This may lead to many services not appealing claims, or not properly appealing claims, and thereby losing money which they are owed. Finally, there are provisions of the new Rule that are difficult to categorize as good or bad, for instance the creation of the new HHS dedicated ALJs. This could be a good thing for medical providers in that now ALJs will be more familiar with Medicare policy, however Medicare may now be more aggressive in arguing their side of these appeals.

Discussing the issue of Medicare appeals gives me the opportunity to raise a side issue: just because an ambulance claim is denied does not mean that it should not have been paid. Ambulance claims constitute a relatively small portion of all Medicare claims, and therefore the ambulance industry is not the top priority when it comes to training the Medicare Carrier's employees. Also, ambulance claims do not use the same coding procedure as virtually every other healthcare industry does. These things often lead to improperly denied claims for ambulance service. By following the proper appeal procedures and making the appropriate medical or legal/coverage arguments, often denied ambulance claims can be recovered. Of the claims that I handle on appeal on behalf of ambulance service clients, the vast majority are successful. The new rules will make the appeals process a little more difficult to navigate, however do not let that discourage you from seeking payment for claims that you feel were appropriate.

The published Rule is an "interim" final rule and is effective as of May 1, 2005, however CMS accepted comments on the Rule until May 9, 2005, therefore in the next few months there should be an additional publication in the Federal Register that will address some of the comments and questions as well as any changes that CMS deems appropriate. Even though the Rule is currently effective, it will take a while to get it implemented. The target dates for implementation are May 1, 2005, for Part A claims and January 1, 2006, for Part B claims.

To read the entire Federal Register publication, go to:

<http://frwebgate3.access.gpo.gov/cgi-bin/waisgate.cgi?WAISdocID=22954328074+3+0+0&WAIAction=retrieve>

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