Lesson Objectives

Upon completion of this lesson, the CAC candidate will:

- Recognize why denials occur
- Understand applicable appeal rules and when an appeal is appropriate
- Describe several effective appeal strategies

Why Appeal?

- Individual payment denial
  - Is it a Medicare “Technical denial?”
  - Consider reopening instead?
  - Is it a Medicare “medical necessity denial”?
  - May not be properly payable by Medicare, and may have to be billed to patient, or other payor – Medicare is the secondary payor
Why Appeal?

- Overpayment demand
  - Post Payment review - with extrapolation
  - Post-payment review without any extrapolation
- Pre-payment review, resulting in denials

General Overview of Medicare Appeals Regulations

Appealing to Medicare

- Govern Part A & Part B appeals
- Outlined at 42 CFR Part 405
- Strict set of procedural rules
- Strict appeal deadlines must be followed

Appealing to Medicare

- Applies to any time a provider wants to challenge a payment denial or overpayment demand that comes from Medicare
- Can be one trip or 100 trips (or more) – all follow same appeal rules
- Follow the rules outlined in the regulations

Denial of Individual Transport

- Explanation of Benefits (EOB) may shows an automatic denial based on an “edit” in the computer processing system
  - Figure out why
  - Simple technical issue (i.e. wrong Medicare number of the patient, or patient name spelled wrong on claim)
  - Improper ICD-9 code

Payment Denials on Submission
Denial of Individual Transport

- Did contractor see documentation, and do you disagree with their determination?
- Is there a glitch in the system, that can’t be corrected immediately, and appeal is needed to preserve rights?

Pre-Payment Denials

- Medicare may implement a pre-payment review
- Claim is submitted, Medicare sends provider “ADR” Additional Document (or Development) Request
- Provider sends information back to Medicare (PCR, PCS, other information to support why claim was billed at the level of service)

Pre-Payment Denials

- If EOB comes back (after information is reviewed) as a denial, may have to appeal (if you believe it’s payable)
- Can batch many transports together
- Use standard appeal forms, or use cover letter
- Outline reasons the transport(s) should be payable

Payment Denials

- No additional request for documentation
- Generally, no payment was received, and provider must appeal to get paid for a claim, or group of claims that Medicare denied
- May have to concede that a trip was properly denied
  - Example: Medical Necessity not met, PCS form invalid, documentation poor

Top Medicare Denial Issues

- Medical necessity
- Interfacility transports and inpatient bundling (Part A)
- Mileage and “closest appropriate facility” rules
- Determine whether appeal is appropriate, or if another payor needs to be billed

Medicare Denials

- Many Medicare denials can be an “easy fix”
  - Identification number/name error
  - Zip code of origin location is missing
  - Improper Modifier, HCPCS or ICD-9 Code
- File redetermination requests where appropriate, or file a reopening, or simply resubmit a denial (if possible)
Denial Reports

- Your software can usually furnish a report
  - Types of denial
  - Number or percentage of denials
  - Denials by payor
- Learn why claims deny
  - Can the process of producing claims be improved to avoid denials?

Denial Follow Up

- Denials can tell you about your billing operation:
  - Claims submitted wrong, or glitch with Contractor?
  - Documentation poor, or Contractor not understanding Medicare payment rules?
  - Track success of appeals or re-filings – what arguments worked?

Post Payment Denials/Overpayments

- Ambulance service targeted by Medicare for a review
  - History of overpayments
  - High utilization rate
  - Complaint
  - Other payor review revealed payment error

Post Payment Review

- Medicare selects “sample” for review (paid claims)
- Provider submits documentation to support claim
- Medicare reviews documentation and decides whether claims were paid properly

- Another contractor, known as the “Program Safeguard Contractor” (PSC) reviews the documentation
  - Some examples of PSCs: TriCenturion, AdvanceMed, Safeguard Services
**Post-Payment Review**
- Initial Determination Letter from PSC
  - Outlines initial findings
- “Demand” Letter from Carrier/MAC
  - States overpayment amount and liability of provider
  - Triggers appeal rights with demand letter
- Watch the mail closely – strict time limits to respond!

**Overpayment Demand**
- Post-payment basis – Medicare already paid for the service
- Upon review, Medicare thinks payment was made in error
- Provider must fight to try to keep money it already received
- Medicare essentially “denies” a transport after payment was made

**Overpayment Demand**
- Rebuttal letter due within 15 days after demand letter from Contractor/MAC
- Address why repayment would cause financial hardship
- “Offset” typically starts on day 41 if repayment or appeal is not submitted by day 30

**Offset**
- Medicare believes that the provider has a “debt” to Medicare – it received money for transports that failed to meet Medicare payment requirements
- Wants to collect this money back
- If repayment is not made, or appeal is not submitted, Medicare will “offset” the debt against current claims

**Levels of Appeal**
- First – Redetermination
- Second – Reconsideration
- Third – Administrative Law Judge
- Fourth – Medicare Appeals Council
- Fifth – Federal District Court

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Basic Rule

Whenever you have an initial claim denial or an overpayment demand following an audit, you have **120 days** to file an appeal (redetermination appeal)

Or else, **all appeal rights will be lost**!

Follow appeal instructions and deadlines carefully!

First Level of Appeal “Redetermination”

Redetermination Level

- 120 day appeal deadline (submit by day 30 to avoid offset)
- Simple appeal to preserve rights
- If appeal is not submitted, appeal rights are lost
- Make simple arguments that transport was properly payable (assuming it was)

Second Level of Appeal “Reconsideration”

Reconsideration Level

- 180 day appeal deadline (from date of redetermination decision)
- To prevent offset, appeal within 30 days of the redetermination decision
- All information must be presented at this level – no new information can be presented at subsequent levels (unless “good cause” exists)
Reconsideration Level

- Appeal is sent to the “QIC” – the Qualified Independent Contractor
- QIC will review the documentation and arguments and provide a decision (usually within 60 days of filing the appeal at this level)

Reconsideration Appeal

- Submit all documents to support the argument that the claim is payable
- Raise medical necessity and extrapolation arguments (as applicable)
- Use medical and/or statistical expert
- Provide as much information as possible

Support Appeal With...

- Letters and affidavits from physicians or other providers
- Records from other providers or facilities
- Patient photographs/videos, showing condition, ambulatory status, etc. (with consent, of course!)
- Any document to support why patient needed an ambulance

Additional Documents

- Signature verifications
- Past reviews that may have been appealed and won
- CMS Regulations, Manuals, Transmittals
- Documents obtained after first level of appeal

Reconsideration Appeal

- All paper submissions – must be clear, concise and thorough
- Fair hearing level with face to face communication is GONE!
- Remember – if documentation doesn’t support your position, consider conceding (all or in part – e.g. downcode)

Third Level of Appeal

“Administrative Law Judge”
Administrative Law Judge

- After QIC issues reconsideration decision, there is 60 day time limit to appeal to ALJ
- Submit written request for hearing
- Offset can resume – law does not prevent offset with filing of appeal!
- ALJ hearing will be in person, teleconference, or videoconference

Offset - revisited

- Consider entering into “extended repayment plan” to prevent offset from occurring
- Make monthly repayments to Medicare instead of offset – lets Medicare money come in the door
- Does not admit liability, or prevent future appeals

MAC Level After ALJ Decision

- If ALJ decision is unfavorable, provider can request Medicare Appeals Council (“MAC”) review (Note: Different than the Medicare Administrative Contractor “MAC” that replaces the Carriers and Fiscal Intermediaries)
- MAC Reviews entire file & hearing transcript
MAC Level After ALJ Decision

- No “hearing” at this level
- MAC makes decision “on the record”
- Usually defers to CMS and takes broad reading of the rules and laws

MAC Level After ALJ Decision

- Note that the QIC is permitted to request that the MAC review an ALJ decision “on the MACs own motion”
- Gives copy of ALJ decision to MAC and outlines why the ALJ decision was improper
- Usually occurs where ALJ was favorable to the provider

Fifth Level of Appeal

- Federal District Court is the final level
- Rare that appeals go to the Medicare Appeals Council (MAC) or Federal District Court
- Most cases end with the decision by the Administrative Law Judge

General Medicare “Appeal Strategies”

Medicare Appeal Strategies

- Organization is key!
  - Keep relevant information for each transport organized and together
  - Cite regulations, laws, prior decisions, etc.

Medicare Appeal Strategies

- Concessions are not always bad!
  - Willingness to concede clearly unsupportable claims shows good faith
  - Establishes your credibility for ones you really want to challenge

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Medicare Appeal Strategies

- Point out where prior decisions were wrong!
  - Cite Manuals and Rules
  - Repeat key and important phrases
  - Know the rules COLD!
  - Be honest and truthful in the evidence and opinions you’re stating

Common Contractor Mistakes

- MUST attack these mistakes
  - Applying non-emergency standards to emergency trips
  - Fail to consider second half of non-emergency criteria – only look at bed confined test
  - Misunderstanding basic Medicare rules (i.e. ALS assessment definition)

Extrapolation

- Applies to “post-payment” review that used statistical sampling and “projection”
  - “Medical necessity” arguments
  - Challenging extrapolation
  - Creates a “two-part” battle on the appeal – challenge individual transports and use of extrapolation

Extrapolation

- Technical (mathematical) and legal arguments to challenge:
  - Whether sampling, methodology, calculations were done correctly from a mathematical perspective and
  - Whether use of extrapolation was proper at all, under the law

Extrapolation

- Small sample of trips are reviewed (30) from a larger universe (4,000) of all transports over a specific time period (1-2 years)
- “Error rate” from the sample is calculated and Medicare assumes that same error rate applies across the entire universe

Extrapolation

- The result: a $2,000 overpayment among a sample of 30 reviewed claims becomes an overpayment of over $250,000 from a 4,000 transport universe
- Liability becomes huge, and provider must challenge the application of extrapolation to reduce total overpayment
“Medical Necessity” Considerations in Denials and Appeals

The Basic Rule . . .
- Ambulance service is medically necessary only if the patient’s condition is such that use of any other method of transportation is contraindicated.
- Was this basic requirement met, and if so, was payment “denied” for which an appeal is warranted?

Medical Necessity
- This can be demonstrated by establishing that certain “presumed criteria” were met.
- Medicare Manual 100-2, Chapter 10, Section 20 outlines certain “presumed criteria” for establishing medical necessity.
- Usually, if one (or more) of these are met, transport is “medically necessary.”

Medical Necessity
- BUT, the key question is: Is there clear documentation to support your argument that medical necessity requirements were met?

Medical Necessity
- “Paint a picture” as to why the patient needed to be transported on a stretcher in an ambulance, relying on the documentation on the PCR, PCS or anything else, and
- That the patient could not be transported safely by other means (assuming that is true and can be supported by the documentation).

Mileage and Destination Issues
Local Transport

- Medicare covers “local” transport only
- Medicare refers to a “locality rule” as outlined in CMS Manual 100-2, Section 10.3.5
- On review, Medicare may “downcode” mileage if transport didn’t go to closest appropriate facility

Locality

- “Locality” is the area surrounding the institution (hospital or other destination) from which people usually come from to seek medical care (hospital’s normal “catchment area”)
- Could be large or small, depending upon urban or rural nature of the area, number of facilities, or available services in the area

Locality

- Several hospitals may fall within the same “locality” and transport to any facility within the “locality” may be covered

Locality Rule in Appeals

- Obtain information/statistics from hospitals to find out where patients may regularly come
- Rebut the Contractor’s “locality” guideline if one exists – it may be old and out of date

“Nearest Appropriate Facility”

- Medicare makes payment for patients that are transported to the “Nearest” or “closest appropriate facility”
- Must have the services, staff, etc. to meet the needs of the patient

Nearest Appropriate Facility

- A “better equipped”, or “better staffed” facility does not make it more “appropriate” than another
- A particular facility is not inappropriate merely because the physicians are “less experienced” at a particular service or procedure
Excess Mileage

- If closest appropriate facility is bypassed, due to patient or physician preference, Medicare will only pay for mileage to that closer facility.
- If closest appropriate facility is bypassed because it is on “divert status” or does not have capabilities to treat pt at that time, mileage to more distant facility may be appropriate.
- May have to concede to a “downcode” on mileage if documentation doesn’t support the need for excess mileage.
- May be able to bill patient.

Appeal Strategies

- Regular training for all billing staff
  - Ensure all billers and coders receive periodic updates and training
  - Catch errors and omissions in the pre-billing process
  - Look at payments and denials for possibility of appeal

Managed Care Appeals

Medicare Managed Care

- Medicare Managed Care Manual – Chapter 13
  - Beneficiary Grievances, Organization Determinations and Appeals
  - Section 60.1.4 - “A non-contracted provider, on his own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal.”

Medicare Managed Care Appeals

- Non-contracted provider rural area
- Patient needed routine transport
- No contracted provider available
- May need to file initial claim, let it deny, then send appeal explaining circumstances
- Must file the dreaded “Waiver of Liability”
Medicare Managed Care Appeals

- If contracted, contract rules, and appeal rights and procedures will be outlined in the contract – Medicare rules may be adopted
- Non-contracted emergency providers are supposed to be paid Medicare allowable, less co-pay and deductible
  - Appeal if not paid Medicare allowable

Medicaid Appeals

- Same general strategies as Medicare
- But – state will have specific rules for appealing and the related procedures
  - Medicaid MCO appeals may follow different set of rules!
- Rely on state case law and past decisions

Medicaid Appeals

- Be familiar with Medicaid Program guidance documents, memo, bulletins, regulations, and other payment standards
- Many states publish “Provider Handbooks” for each provider type that outlines denial, appeal, and payment issues that must be followed

Commercial Insurers

- Not nearly as strict as Medicare and Medicaid
- Audit (post payment review) is rare – legal authority is questionable (may be primary challenge in any appeal)
- Claim-by-claim denial is the most common approach
Common Commercial Denials

- Down-coding/Partial payments
- Base rate paid but not mileage
- Mileage paid at incorrect rate
- Medical necessity
- Some commercial insurers have adopted Medicare definitions for levels of service

Know What Rules Govern

- Applicable appeal rules may come from many sources
  - State laws and regulations
  - Provider contracts
  - Insurance policies of insured

Look for Helpful State Laws

- Prompt pay laws
- Direct pay laws
- “Any willing provider laws”
- Appeal requirements
- Note: not all states have all (or any) of these laws – check your state law to be sure!

Impact of Provider Contracts

- If you have a contract with insurer, it may “incorporate by reference” the plan’s appeal policies
- You may be bound by those rules even if they are not spelled out in contract itself
- Make sure you obtain a copy of any applicable rules from the plan (if they exist)

Commercial Appeals Strategies

Commercial Appeals First Step: Know the Rules
Know the Rules

- Appeal rules may come from
  - State laws and regulations
  - Provider contracts
- Helpful resources
  - State Insurance Department website
  - Payor’s website or other guidance
  - State provider association website

Determine if You Have Appeal Rights

- May be an issue if you billed the claim on a non-assigned basis
- Some plans and policies require an assignment to allow a provider to appeal a claim on behalf of an insured

Commercial Appeals

Second Step: Determine if You Have Appeal Rights

- Some plans may take the position that the insured must specifically assign appeal rights
- In other words, an insurer may take the position that a general “assignment of benefits” is not enough
- Good reason to include a specific assignment of appeal rights in your signature language

Commercial Appeals

Third Step: Follow the Applicable Appeal Process

- Know where/to whom you should send your appeal
- Use the correct form if there is one
- Support your appeal with all necessary documentation
Follow the Applicable Appeal Process

- Remember, the commercial appeals process may involve several levels of review, both “internal” and “external”.

Commercial Appeals
Fourth Step: **Document!**

**Document, Document Document!**

- Retain copies of all appeal letters, forms and supporting documentation sent.
- Consider certified mail or other documented delivery method (Fed Ex) for tracking and verification of receipt purposes.

**Document, Document, Document!**

- Keep notes of all phone conversations regarding the appeal or the appeals process.
- Use e-mail as written receipt of communications, if possible.
- Follow-up conversations with e-mail or letter (“it is our understanding that . . .” or “you advised us . . .”)

Commercial Appeals
Fifth Step: **Be Tenacious!**

**Be Tenacious!**

- Enlist professional assistance when necessary, including legal counsel.
  - If you’re having the problem, chances are that other ambulance services are too.
- Utilize state insurance department.
Be Tenacious!

- In many cases, the insurer’s hope is that the provider simply will give up!
- A wise man once asked: “How much would you spend to make a million dollars?”
- The answer: $999,999.99!

Carefully review claims at issue
- Perform self audit to assess whether or not claims are properly payable – be self-critical!
- Consider additional information and evidence that may exist
- Consider using outside legal counsel
- Don’t give up easily!

Improve Front End Operations

- Many appeals are won or lost before the ambulance rolls!
- Improve call intake, billing and documentation processes
- Improve QA process to incorporate medical necessity documentation, reason for transport and other claim-related indicators

Use Supplemental Documentation

- You are not limited to the PCR and PCS forms to support your claims!
- May use other sources of medical necessity documentation
  - Testimony, hospital records, expert reports, etc.

Final Options

- If every level of internal and external review was tried without success
- May choose to notify Insurance Commissioner or State Department of Insurance
- Possibility of court action

Summary

- Reviewed the basic reasons when you would appeal a denied claim
- Discussed the different “levels of appeal” for Medicare
- Described differences between Medicare and other payor appeals
- Outlined specific strategies that can help you “win” an appeal