Appealing Medicare Fee-For-Service Claims

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On March 1, 2005, the Centers for Medicare & Medicaid Services (CMS) published an interim final rule[1] (the Rule) overhauling the appeals process for Medicare fee-for-service claims, including appeals of denials for all claims on which a physician has accepted assignment. This process would apply where a physician receives a denial for an oncology or other drug covered under Medicare Part B, and the physician would like to appeal the denial.

The most significant change is the unification of the processes for appealing denials and overpayments related to Part A and Part B services, including those furnished by physicians and hospitals. Other features of the Rule also are important to providers because they fundamentally alter the parties, process, and procedures for Medicare appeals. This column highlights the most notable changes.

The Rule lifts the current restrictions on who may file an appeal—beneficiaries and providers now have the same right to appeal. As a result, providers are no longer required to submit an Appointment of Representative form signed by the beneficiary before proceeding with an appeal.

Combining the processes for bringing Part A and Part B appeals. The first-level appeal, called a "redetermination" under the Rule, remains with the fiscal intermediary (FI) or carrier. However, all second-level appeals, called "reconsiderations," will now come before a new entity known as a Qualified Independent Contractor (QIC), and carrier fair hearings will no longer be held. The QICs are already processing reconsiderations of FI redeterminations issued on or after May 1, 2005. For carrier redeterminations, the new QIC procedures will apply to decisions rendered on or after January 1, 2006.

The QICs will conduct reconsiderations using a panel of healthcare professionals. The panel's composition will change based upon the nature of the claim. For example, if the appeal involves medical necessity, a panel of physicians or other qualified healthcare professionals must consider the appeal. Similarly, if the claim involves items or services provided by a physician, a reviewing professional must be a physician. CMS has touted the QICs' independence from CMS, but providers should be wary. QICs, FIs, and carriers are Medicare contractors and therefore may feel beholden to CMS when making decisions.

From a procedural standpoint, the FI and QIC generally must process redeterminations and reconsiderations, respectively, within 60 days of receipt of a timely and complete request. Administrative law judge (ALJ) and Medicare Appeals Council (MAC) decisions must be rendered within 90 days of receipt. Providers can take their cases to the next level of review if decision deadlines are not met. Other procedural changes include elimination of the amount in controversy requirement for second-level appeals, and revision of the monetary thresholds for ALJ and federal district court appeals to adjust annually for inflation.

Expanding CMS's role. The Rule also expands CMS's involvement in the appeals process. In the past, neither CMS nor the contractor served as a party to appeal because the process was non-adversarial, but ALJs now can request their participation in hearings. In addition, CMS (and/or its contractor) may, on its own motion, seek party status. This change is likely to result in increased costs for providers, who will be expending additional effort to rebut motions, arguments, and witnesses. CMS's participation also may reduce the likelihood of a favorable outcome.

Moving ALJ appeals to HHS. Responsibility for ALJ appeals will transition from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS). Medicare contractors were scheduled to begin sending new appeal requests to HHS on July 1, 2005, while SSA should complete processing of remaining Medicare appeals no later than September 30, 2005.

This transfer of responsibility will result in a vastly reduced number of in-person hearing sites, and ALJ hearings now must be conducted by video-teleconferencing. The ALJ may hold an in-person hearing only if the technology is unavailable or if "[s]pecial or extraordinary circumstances exist."

Providers should not underestimate the impact of these changes. Most important, providers should approach appeals with caution because errors early on can have grave implications later in the process. For example, under the Rule, all evidence in the case must be submitted before the QIC renders its determination, or the evidence will be barred from consideration in all subsequent proceedings, including the ALJ hearing.

Given CMS's expanded role in the process, these changes will also result in an overall experience that is more likely to be adversarial. Competent legal representation will be important, especially in cases concerning a large number of claims or an overpayment based on a statistical sampling. At a minimum, providers should prepare by reviewing and updating policies and procedures for handling Medicare denials and appeals as necessary.

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References

[1] 70 Fed. Reg. 11420 (Mar. 8, 2005).