A New Compliance Challenge: Appealing Medicare Claims Denials

Providers and Suppliers Must Understand How to Challenge Improper Denials of Payments

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Compliance with all the legal, regulatory, and program requirements relating to provider/supplier participation in the Medicare program is an ongoing challenge for health care providers and suppliers. Among the issues faced is keeping current in understanding and complying with program requirements and ensuring timely and complete Medicare payments for items and services furnished to program beneficiaries. Increasingly, provider and supplier claims are being denied or challenged by Medicare administrative contractors (MACs) or payment safeguard contractors, such as recovery audit contractors (RACs) and zone program integrity contractors (ZPICs). To respond appropriately, providers and suppliers need to understand and use the Medicare claims appeals process to challenge improper denials of Medicare payments.

Health care providers and suppliers have the right to appeal the denial of Medicare coverage and payment for an item or service furnished to a program beneficiary.1 Over the past 15 years the Medicare appeals process has undergone a number of changes. In addition, the volume of appeals has grown dramatically. For example, in fiscal year (FY) 2012 (October 1, 2011 - September 30, 2012), over 130,000 requests for administrative law judge (ALJ) review of lower level “reconsideration” decisions encompassing over 312,000 claims were received by the Office of Medicare Hearings and Appeals (OMHA) in the U.S. Department of Health and Human Services (HHS).2 During the same time period, the Medicare Appeals Council, the highest level of administrative review within HHS, received over 3,000 appeals involving almost 15,000 claims.3
Due to limited governmental resources, there are significant delays and problems in obtaining a timely adjudication of appeals. Therefore, it is important that providers and suppliers understand the administrative appeals process established by HHS and comply with the governing regulations and procedural requirements to obtain timely and fair consideration of their Medicare claims appeals.

**BACKGROUND**

A unified appeals process exists for provider and supplier appeals of claim denials under both Medicare Parts A and B. The current appeals process was established by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. 106-554) and is codified in section 1869 of the Social Security Act (Act). Regulations governing Medicare appeals are set forth in 42 CFR Part 405, Subpart I. Under the current appeals system, there are five levels of review:

1. Redetermination of an initial decision by a MAC
2. Reconsideration by a qualified independent contractor (QIC)
3. Hearing before an ALJ
4. Review by the Medicare Appeals Council
5. Review by a federal District Court

A major feature in the 2000 legislative changes to the Medicare appeals process was the establishment of timeframes for consideration and decision at each stage of review. For example, a MAC must issue a redetermination within 60 days of receipt of an appeal. Similarly, a QIC must issue its reconsideration within 60 days of receipt of a request for review. Further, both an ALJ and the Council are obligated to issue a decision within 90 days of receipt of an appeal. If a QIC, ALJ, or the Council does not render a decision in a timely manner, an appellant may request escalation of an appeal to the next higher level of review.

Another key provision was the establishment of QICs to perform an independent review and the requirement that all evidence be submitted at the QIC's reconsideration level. Accordingly, at the ALJ level of review, no additional documentary evidence may be introduced by a provider or supplier unless there is “good cause” for not submitting it at the reconsideration level of review.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 106-554) mandated further changes in the Medicare appeals structure and transferred the responsibility for ALJ hearings from the Social Security Administration to HHS. Accordingly, in 2005, OMHA was established within HHS. Currently, OMHA has 68 ALJs and support staff based in four regional offices. While cases are randomly assigned to ALJs based in four regional offices, all requests for ALJ review must be filed through the OMHA centralized docketing system in Cleveland, Ohio.

**APPEAL CONSIDERATIONS**

Key to success in appealing Medicare claims denials is understanding and complying with all regulatory and procedural requirements. Failure to comply with a specific timeframe or filing requirement may result in dismissal of an appeal or an adverse decision. Therefore, it is important that there be an understanding and familiarity with the provisions and requirements contained in the governing HHS regulations, which are codified in the Code of Federal Regulations, Title 42, Subpart I (Determinations, Redeterminations, and Appeals Under Original Medicare (Part A and Part B)).

**REDETERMINATION (42 CFR 405.940 - 42 CFR 405.958)**

Upon receipt of an adverse initial determination by a MAC, a provider or supplier has 120 days to request a “redetermination.” Such a request may be filed using and sending a completed Form CMS-20027 to the MAC. A MAC is obligated to issue a redetermination decision within 60 days of receipt of a request.
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Appeal is not received within the prescribed timeframe, unless there has been an extension (e.g., due to submission of additional evidence), an inquiry to either the MAC’s appeals staff or the Centers for Medicare & Medicaid Services (CMS) regarding receipt and status of the appeal is warranted. Reported data has indicated that, generally, redetermination decisions reaffirm the initial adverse claim determination issued by the MAC. Therefore, appeal to the next level of review is usually necessary.

**RECONSIDERATION (42 CFR 405.960 - 42 CFR 405.405.978)**

Reconsideration allows for an independent evaluation of a claim for Medicare payment by a QIC. Section 1869 of the Act contains specific “provisions regarding the independence of the QICs, qualification requirements for QICs, the role of the QIC panel, and continuing education for QICs with respect to Medicare coverage of items and services.” The requisite qualifications for QIC reviewers are specified in the governing regulations. For example, “[w]here a claim pertains to the furnishing of treatment by a physician, or the provision of items or services by a physician, a reviewing professional must be a physician.” A written reconsideration request must be filed with the QIC within 180 days of receipt of the redetermination decision. Such a request may be filed using a Form CMS-20033, or similar information in writing, along with supporting documentation.

A key consideration in presenting an appeal to a QIC is the requirement that all evidence must be submitted at the QIC level of review, and additional and new documentation generally will not be considered by an ALJ (or the Medicare Appeals Council) unless there is “good cause” for the late submission of evidence. The QIC is required to issue a decision within 60 days of receipt of a request for reconsideration. If a QIC cannot meet the prescribed deadline for issuing a reconsideration decision, it must notify the parties “and offer the appellant the opportunity to escalate the appeal to an ALJ.” If an appellant desires escalation to the ALJ level of review, it must notify the QIC in writing. After the receipt of such written notification, the QIC has five days to either issue its reconsideration decision or acknowledge the request for escalation in writing and forward the case file to OMHA for assignment to an ALJ.

At the QIC level of review, it is important that a provider or supplier present all relevant evidence supporting Medicare coverage and payment of a claim as well as “allegations of fact or law related to the issue in dispute.” Failure to submit documentation may preclude future introduction of such evidence at higher levels of review. In addition, attention and citation to the controlling law, regulations, CMS rulings, and national coverage determinations (NCDs) is important. The QIC is required to apply these authorities in its review of an appeal. While it is not required to apply local coverage determinations (LCDs) or CMS Manual provisions, it must “give substantial deference to these policies if they are applicable in a particular case.” If a reconsideration decision is not received within the 60-day timeframe, then consideration should be given to requesting escalation of an appeal to an ALJ for review.

**ALJ REVIEW (42 CFR 405.1000 - 42 CFR 405.1064)**

A request for ALJ review of an “unfavorable decision” by a QIC must be filed with OMHA within 60 days of receipt of the QIC’s reconsideration decision. A party has the right to seek ALJ review if the “amount in controversy” requirement is met. Generally, the “amount in controversy” requirement is easily met. In 2013, the required amount in controversy is $140 for the right to request ALJ review. A request for ALJ review may be made using Form CMS-20034 or by providing similar information in writing. An appellant is also obligated to send a copy of its request for an ALJ hearing to other parties, includ-
ing beneficiaries.\textsuperscript{32} An ALJ is required to decide an appeal within 90 days of receipt of the request for review.\textsuperscript{33}

It is important to recognize that CMS or its contractor has the option to elect to either “participate” or be a “party” in an ALJ hearing. If it elects to participate, it is allowed to file “position papers or provid[e] testimony to clarify factual or policy issues in a case.”\textsuperscript{34} If participation is elected, CMS (or its contractor) is not allowed to call witnesses or cross-examine a party’s witnesses, and its representative may not be called as a witness.\textsuperscript{35} However, if CMS (or a contractor) elects to be a party in an ALJ hearing, it “may file position papers, provide testimony to clarify factual or policy issues, call witnesses or cross-examine the witnesses of other parties.”\textsuperscript{36} Generally, CMS usually elects to participate in ALJ hearings (as opposed to being a party) and is represented by the appropriate MAC.

A party is not entitled to an “in person” hearing. HHS has determined that the statute “does not specify the manner in which hearings must be held.”\textsuperscript{37} Therefore, “the Secretary [of HHS] concluded that the expanded use of VTC [video teleconferencing] and telephone hearings for Medicare appeals is appropriate.”\textsuperscript{38} Generally, OMHA responds to requests for ALJ review by scheduling a telephone hearing with an ALJ.

At such a hearing, the ALJ is obligated to “fully examine the issues, question the parties and other witnesses, and...accept documents that are material to the issues...”\textsuperscript{39} However, as previously noted, no additional documentary evidence will be accepted by an ALJ unless “good cause” is demonstrated for the “late submission.”\textsuperscript{40} This “early submission” requirement does “not apply to oral testimony given at a hearing, or to evidence submitted by an unrepresented beneficiary.”\textsuperscript{41} An ALJ also has the option to decide a case without a hearing if the evidence in the record supports a finding in favor of the appellant on every issue or if all parties indicate in writing that they do not wish for there to be a hearing.\textsuperscript{42} Applicable laws, regulations, CMS rulings, and NCDs are binding on an ALJ.\textsuperscript{43} While LCDs and CMS Manual provisions are not binding, they must be given “substantial deference... if they are applicable in a particular case.”\textsuperscript{44}

As noted above, an ALJ is required to decide a case within 90 days of receipt of a provider's or supplier's request for review.\textsuperscript{45} If an ALJ fails to comply with this deadline, a party has the option of filing with the ALJ a written request for escalation of the appeal to the Medicare Appeals Council. If the ALJ does not issue a decision, dismissal, or remand in the case within five days of receipt, the appellant is notified and can seek review by the Council.\textsuperscript{46} In such escalation cases, the Council then has 180 days to review the appeal and issue a decision, dismissal, or remand order.\textsuperscript{47}

At the ALJ level of review, it is important that a provider or supplier confirm that all documentary evidence that was presented at lower levels of review is in the record before the ALJ. The appeals process does not have an electronic or consistent process for transferring case files from one level of review to the next higher levels. Thus, while a QIC may convert documentation to “electronic format,” OMHA and the ALJs use and review “hard copy” paper files and documents. Therefore, prior to a scheduled hearing, a provider or supplier should confirm that all documentation is in the record before the ALJ as a properly listed exhibit. Moreover, to the extent that testimony may be presented about particular documents, e.g., medical records, such records should be paginated to ensure that at the hearing, which is usually by telephone, the ALJ will be able to follow the testimony and record being reviewed.

Prior to the hearing, it is also useful for a provider or supplier to prepare and present a prehearing memorandum outlining the issues being appealed, the applicable law, regulations, CMS ruling, NCD, or other authority, as well as medical record and related documentation supporting the appeal. While not precedential, prior decisions by
the Medicare Appeals Council also may be referenced as support for an appeal. Significant Medicare Appeals Council decisions are available on its Web site or West Law.48

Generally, the issues to be decided by an ALJ include the following:

- Is there a Medicare statutory benefit category covering the claimed item(s) or service(s)?
- Is there a statutory preclusion to Medicare coverage of the claimed item(s) or service(s)?
- Are the claimed items or services reasonable and necessary for the beneficiary?

Since these issues will be adjudicated by an ALJ, it is important that an appellant provider or supplier address these issues in its prehearing filing and reference controlling legal authority and supporting documentation. It must be recognized that a provider or supplier has the burden of establishing that a claimed item or service should be covered by Medicare and that there is sufficient medical record or other documentation to establish that it was provided to a program beneficiary and was "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."49 The Act specifies that "no [Medicare] payment shall be made to any provider of services or other person...unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person."50 Moreover, various federal courts have held that supporting documentation, in addition to a physician order, prescription, or certificate of medical necessity, may be required to establish Medicare coverage and payment.51

In addition, contrary to the QIC, it must be recognized that an ALJ generally does not have medical training and may not be well versed in the medical conditions afflicting a beneficiary or the specific items or services furnished by a provider or supplier. Thus, it is important that testimony and evidence be presented from a "lay person" perspective. At an ALJ hearing, any expert witnesses need to explain the patient's medical condition(s) and indications as well as the services and treatment provided in understandable terms.

**MEDICARE APPEALS COUNCIL REVIEW (42 CFR 405.1100 - 405.1134)**

The Medicare Appeals Council is the final level of administrative review of Medicare claims appeals. A provider or supplier may request Council review of an ALJ decision or dismissal within 60 days of receipt.52 Such a request must be in writing and may be submitted on Form DAB - 101.53 The Council undertakes *de novo* review of the testimony and evidence in a case and is required to issue a determination regarding Medicare coverage and payment of a claim within 90 days of receipt of a request for review.54

Generally, the Council will give a party requesting review "a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case."55 Copies must be provided to other parties as well.56 Generally, no additional evidence may be presented to the Council.57 In addition, while a provider or supplier may request the opportunity to present "oral argument" to the Council, the Council generally does not hear such testimony and relies on a recording or transcript of the testimony at the ALJ hearing and documentary evidence considered by the ALJ.58

Once the Council issues its determination in a case, either affirming the ALJ decision, issuing a reversing or modifying decision, or remanding the case back to an ALJ for further hearing, it represents the final administrative decision of the Secretary of HHS. The decision is final and binding unless a party seeks review by a federal District Court within 60 days of receipt of the Council's decision.59

**PRACTICAL TIPS**

For a provider or supplier to successfully use the Medicare appeals process in challenging the denial of coverage and pay-
ment of a claim, it is important to understand and comply with each procedural requirement, as set forth in the applicable HHS regulations. In addition, some other considerations include:

- compliance with all filing deadlines;
- researching and referencing the applicable law, regulations, and other Medicare authority supporting coverage and payment of a claim;
- obtaining and presenting documentary evidence supporting Medicare coverage of a claimed item and service and demonstrating that it was “reasonable and necessary” for a beneficiary;
- ensuring that other parties, e.g., beneficiaries, are sent copies of a request for either ALJ or Council review;
- ensuring that all evidence is presented at the QIC level of review (to the extent possible);
- ensuring at the ALJ level of review that all documentary evidence presented at the QIC level of review is available and properly identified by exhibit and page numbers; and
- presenting testimony at the ALJ hearing that educates the ALJ on the beneficiary’s medical condition and indications and that the items and services furnished were covered by Medicare and “reasonable and necessary” for the patient.

It is through strict compliance with the HHS regulations governing the appeal of Medicare claims denials that providers and suppliers will be able to prevail in their challenges to Medicare denials of coverage and payment of claims.

**Endnotes:**

1. Although beneficiaries also have the right to appeal an adverse decision regarding Medicare coverage and payment of a claim, the predominant “users” of the appeals process are providers and suppliers. Thus, this article is primarily directed toward them.
2. Data obtained from the HHS Office of Medicare Hearings and Appeals (OMHA).
3. Data obtained from the HHS Departmental Appeals Board.
4. 42 USC 1395ff.
5. Separate procedures have been established for appealing the denial of payments under Medicare Parts C and D. The Medicare Part C appeal procedures may be found in 42 CFR Part 422, Subpart M, and the Medicare Part D appeal procedures are set forth in 42 CFR Part 423, Subpart U.
6. 42 CFR 405.950(a).
7. 42 CFR 405.970(a).
8. 42 CFR 405.1016(a); 42 CFR 405.1100(c).
9. 42 CFR 405.970(c)(2); 42 CFR 405.1104; 42 CFR 405.1132.
10. 42 CFR 405.966(a)(2).
11. 42 CFR 405.1018(c). The requirement regarding early submission of evidence does not apply to oral testimony at a hearing or the submission of any documentation by an unrepresented beneficiary. 42 CFR 405.1018(d).
12. Data obtained from OMHA.
13. 42 CFR 405.942(a).
15. 42 CFR 405.950(a).
17. 42 CFR 405.968(c)(3).
18. 42 CFR 405.962(a).
19. 42 CFR 405.964.
20. “Absent good cause, failure to submit all evidence, including documentation requested in the notice of redetermination prior to the issuance of the notice of reconsideration precludes subsequent consideration of that evidence.” 42 CFR 405.966(a)(2).
21. 42 CFR 405.970(a).
22. 42 CFR 405.970(c)(2).
23. 42 CFR 405.970(d).
24. 42 CFR 405.970(3)(2).
25. 42 CFR 405.966(a).
26. 42 CFR 405.968(b)(1).
27. 42 CFR 405.968(b)(2).
28. 42 CFR 405.1002(a)(1); 42 CFR 405.1014(b)(1).
29. 42 CFR 405.1006.
30. 77 Fed.Reg.5918 (September 28, 2012). A provider or supplier also has the option of “aggregating” two or more claims involving common issues of law or fact or delivery of similar or related services.” 42 CFR 405.1006(e).
31. 42 CFR 405.1014(a).
32. “Failure to do so will toll the ALJ’s 90 calendar day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.” 42 CFR 405.1014(b)(2).
33. 42 CFR 405.1016(a).
34. 42 CFR 405.1010(c).
35. 42 CFR 405.1010(d).
36. 42 CFR 405.1012(c).
37. 74 Fed.Reg.65321 (December 9, 2009).
38. Id.
39. 42 CFR 405.1030(b).
40. 42 CFR 405.1030(d) and (e). “Any evidence submitted by a provider [or] suppliers…that is not submitted prior to the issuance of the QIC’s reconsideration.
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determination must be accompanied by a statement explaining why the evidence was not previously submitted. “42 CFR 405.1018(c).

41. 42 CFR 405.1018(d).
42. 42 CFR 405.1038.
43. 42 CFR 405.1060; 42 CFR 405.1063.
44. 42 CFR 405.1062.
45. 42 CFR 405.1046(d).
46. 42 CFR 405.1104(d).
47. 42 CFR 405.1106(b).
49. Section 1862(a)(1)(A) of the Act; 42 USC 1395y(a)(1)(A).
50. Section 1833(e) of the Act; 42 USC 1395l(e).

51. Gulfcoast Medical Supply, Inc. v. Secretary of DHHS, 468 F. 3d 1347 (11 Cir. 2006); Maximum Comfort, Inc. v. Leavitt, 512 F. 3d 1081 (9th Cir. 2007); MacKenzie Medical Supply, Inc. v. DHHS, 506 F. 3d 341 (4th Circ. 2007).
52. 42 CFR 405.1102.
53. The form for requesting review by the Medicare Appeals Council is available on the HHS Web site at www.dab.hhs.gov.
54. 42 CFR 1100(c).
55. 42 CFR 495,1120.
56. Id.
57. 42 CFR 405.1122.
58. 42 CFR 405.1124.
59. 42 CFRF 405.1130.