THE ANATOMY OF A MEDICARE CLAIMS APPEAL

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APPEAL PROCESS

- 2005 Interim final rule
- 2010 final rule
- Part A and Part B claims
- Inapplicable to cost reports
REBUTTAL/DISCUSSION

- Not part of claims appeal process
- Rebuttal with local Medicare Administrative Contractor
- Up to 15 days
- Discussion period with Recovery Audit Contractor
- Up to 30 days
REDETERMINATION

• Local MAC
• 120 days to request
• Good cause
• 60 days for decision
• De Novo
FIRST-LEVEL APPEAL

- Beneficiary’s name
- Health insurance claim number
- Service(s) and/or item(s)
- Date(s) of service
- Name and signature of appellant or representative
RECONSIDERATION

- Qualified Independent Contractor: 9 QICs
- 180 days to request
- 60 days for decision
- Escalation for delay
- De Novo
- Early and full presentation of evidence
- New evidence
SECOND-LEVEL APPEAL

- Beneficiary’s name
- HICN
- Service(s) and/or item(s)
- DOS
- Name and signature of appellant or representative
- Name of MAC
ALJ HEARING

• Office of Medicare Hearings & Appeals: 4 Field Offices
• 60 days to request
• In-person hearing
• Videoteleconference (VTC)
• Telephone
• On the Record
• De Novo
• 90 days for decision
• Except for in-person hearing
• Request for waiver
• Escalation for delay
THIRD-LEVEL APPEAL

- Beneficiary’s name, address, and HICN
- Appellant’ name and address (if not beneficiary)
- Representative’s name and address (if any)
- QIC appeal number
- DOS
- Reasons the appellant disagrees with QIC
- Statement of any additional evidence to be submitted and date it will be submitted
- Good cause
ISSUES

- 2014 amount in controversy = $140
- Certificate of service
- Independent expert
- CMS or contractor participation
- ALJ request
- 10 days notice
- Limited role
- CMS or contractor as party
- Prohibited if beneficiary unrepresented
- 10 days notice
ISSUES

- 2-year moratorium on scheduling hearings
- Appeals filed on or after July 2013
- Good news for older appeals?
- Alleged overpayments fully recouped prior to hearing date?
MEDICARE APPEALS COUNCIL

- Request for review
- 60 days to request
- 90 days for decision
- Escalation for delay
- No evidentiary hearing
- Written briefs optional
- Oral arguments optional

hfma • tennessee chapter
healthcare financial management association
- CMS appeal
- Administrative Contractor of CMS
- Own motion
Council

• Abuse of discretion by ALJ
• Error of law
• Actions, findings, or conclusions of ALJ not supported by substantial evidence
• Broad policy or procedural issue that may affect general public interest
Federal Court

- Complaint
- 60 days to file
- 2014 AIC = $1430
TRACKING

• Confirmation of delivery
• Follow-up
• Document and copy
**Template**

- Required data elements
- Allegations
- Medicare requirements
- Clinical summary
- Rebuttal of each allegation
- Paginated medical records
STATISTICAL SAMPLING & EXTRAPOLATION

- Office of Inspector General
- Zone Program Integrity Contractors
- MACs
- Audit statistical sample
- Extrapolate error rate
- 4-year look-back period
RECOUPMENT

- Redetermination
  - Begins 41st day after overpayment demand unless appealed within 30 days
- Reconsideration
  - Begins 60th day after Redetermination unless appealed
  - Begins 30 days after Reconsideration
- Interest earned only on amounts recouped

HFMA Tennessee Chapter
Healthcare Financial Management Association
QUESTIONS?

Thank You!