A Strategic Approach to Disputing Audits

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Appeals Process Introduction

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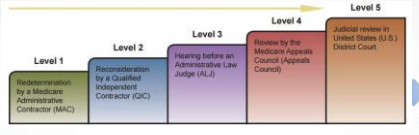
The Medicare Appeals Process



Five levels to the Medicare appeals process

1. Redetermination
2. Reconsideration
3. Administrative Law Judge hearing
4. **Medicare Appeals Council review*
5. **Judicial review in U.S. District Court*

**Require an attorney*

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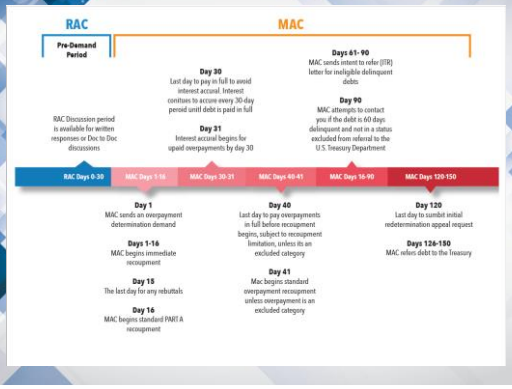
APPEAL TIMELINE



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RAC Overpayment Determination

RAC Discussion Period
Not considered part of the formal CMS Appeals process – 2 formats

Complete RAC discussion request form
Return with medical record or additional documentation to support request

You may request an extension for submission of the Discussion Period Request
During this period, or during the review of your Discussion Period Request, the RAC will **not** submit the claim(s) for adjustments to your Medicare Administrative Contractor (MAC).

Must file a Discussion request within 30 days of receipt* of:
Automated Review: Initial Findings Letter (IFL)
Complex Review: Review Results Letter (RRL)

**The RAC is not required to accept discussion requests after the 31st day from the date on the Informational or Review Results letter.*

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RAC Overpayment Determination

RAC PEER TO PEER TELECONFERENCE
Not considered part of the formal CMS Appeals process

A physician employed with a Hospital or Physician Office may submit a request to discuss an improper payment finding with the RAC's Contractor Medical Director:

Within 30 days of receipt* of Informational Letter for an automated review

Within 30 days of receipt* of Review Results Letter for a complex review.

**The RAC is not required to accept discussion requests after the 31st day from the date on the Informational or Review Results letter.*

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The Medicare Appeals Process

First Level of Appeal: Redetermination

- MAC processes the redetermination
- You must file a redetermination request within **120 days** from the date you received the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice listing the initial determination*
- No minimum amount-in-controversy
- MACs generally issue a decision within 60 days of the date they get the redetermination request.

* The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.

Initial claim denial received → 120 days to file Redetermination request → Up to 60 days for MAC response

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The Medicare Appeals Process

Second Level of Appeal: Reconsideration

- Qualified Independent Contractor (QIC) processes the redetermination
- You must file a reconsideration request within **180 days** from the date you got the MRN*
- No minimum amount-in-controversy
- A QIC generally sends a decision to all parties within 60 days of the date they get the reconsideration request.

* The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.

**If the QIC cannot complete its decision in the applicable timeframe, it will inform you of your rights and the procedures to escalate the case to an Administrative Law Judge (ALJ).

MAC Redetermination decision received → 180 days to file Reconsideration request → Up to 60 days** for QIC response

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Third Level of Appeal: Hearing before an Administrative Law Judge (ALJ)

- You must file an ALJ hearing request within **60 days** from the date you got the reconsideration decision letter or QIC dismissal notice *
- **$180.00** minimum amount-in-controversy (2023)
- For Parts A and B appeals, OMHA has 90 days to complete its review and issue a decision.

*The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.

**OMHA has not been able to meet the 90-day time-frame for adjudication in some cases, resulting in a backlog of appeals for the ALJ

QIC Reconsideration decision received → 60 days to file request for hearing → Hearing and decision within 90 days*

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- **ALJ BACKLOG**
- **As of March 31, 2023, there were *only* 663 appeals that were initiated but have not been adjudicated within 90 days**

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Best Practices for Appeals

Discouraged:

- Using your appeal request as a platform
- Basing appeal on opinion
- Predicating response on precedent decisions

Encouraged:

- Ensure timely filings
- Provide policy and evidence driven support
- Address denial reason(s)
- Utilize appeal path afforded to Suppliers

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Navigating the Appeal Process

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WHY SHOULD YOU APPEAL?

- Maximize Retained Reimbursements
- Lessen the probability of subsequent audits
- Manage your error rate
- Keep from becoming a payer target
- Mitigate risk
- Odds are in your favor

"For repeated infractions, MACs have the discretion to initiate progressively more severe administrative action, commensurate with the seriousness of the identified problem… such as 100 percent prepayment review of claims"

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Do Not Become a Target?

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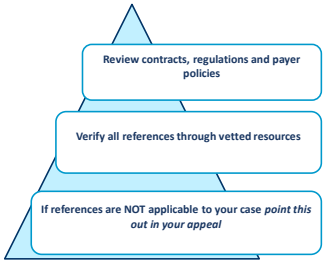
EXPERT TIP: Never assume a denial is correct



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CMS contractors work *together* to identify high claim error rates

The MACs have the discretion to select target areas because of:

- High volume of services;
- High cost;
- Dramatic change in frequency of use;
- High risk problem-prone areas; and/or,
- Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability

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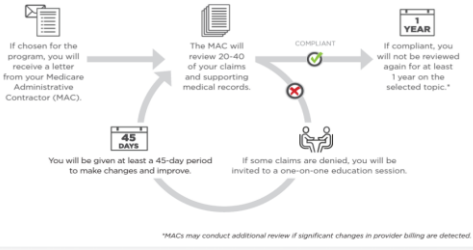
Target, Probe and Educate

HOW DOES IT WORK?



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Critical Appeal Considerations

Offsetting – immediate or standard. The option you selected has a substantial impact on the appeals path

Interest during appeals process – interest is accruing while appeal is in process, this can be substantial

Demands – demands must be resolved in 60 days. Adverse QIC reconsideration – 30 days

Self-Assessment – CMS requires overpayments to be identified and returned to avoid severe penalties

Extended Repayment Schedule – MACs provide the ability to request overpayments relief via extended payment if provider / supplier meets criteria

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Developing an Organizational Appeal Strategy

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STEP ONE – Develop a Successful Appeals Team

Engage staff in each department

- Ensure each department shares in responsibility
- Foster a collaborative environment
- Multidisciplinary approach - Clinical, Billing, Compliance, Intake, etc.

Identify process improvement opportunities

- Changes or additions to workflows, processes and procedures
- Train and educate to reduce errors and build efficiencies

Quality Assessment

- Test execution regularly
- Constantly strive to improve operations and develop team
- Be dynamic - resources must be up-to-date and monitored for changes

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EXPERT TIP: Payer Reviewers Make Mistakes Too

- **Reference guidelines in place at the time of review but not in effect *at the time of service***
- **Retired or expired policies and regulations**
- **Cut & paste reviews with incorrect information**

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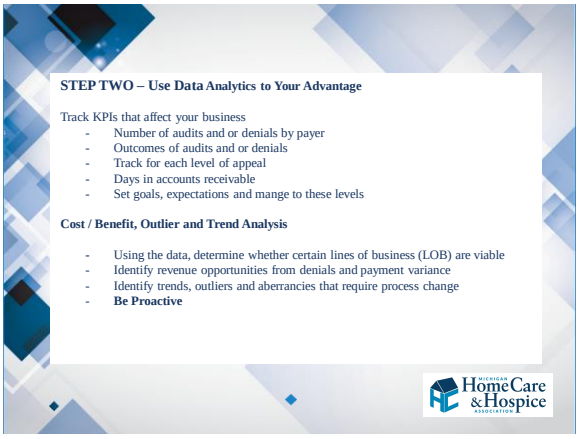
STEP TWO – Use Data Analytics to Your Advantage
Track KPIs that affect your business
- Number of audits and or denials by payer
- Outcomes of audits and or denials
- Track for each level of appeal
- Days in accounts receivable
- Set goals, expectations and mange to these levels
Cost / Benefit, Outlier and Trend Analysis
- Using the data, determine whether certain lines of business (LOB) are viable
- Identify revenue opportunities from denials and payment variance
- Identify trends, outliers and aberrancies that require process change
- Be Proactive
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STEP THREE: Involve leadership
The appeals process can be the conduit for change
- Essential to understand what, why, and when claims are denied and successful outcomes
- Foster and environment that identifies systemic issues, note trends, and corrects issues
- Refine systems to improve execution outcomes
Payer differences are important to business success
- Better understand contract language and nuances
- Understand your appeal outcomes specific to each payer
- Leverage the knowledge gained from the appeal process to minimize business risk and mitigate vulnerabilities
- Use appeal and claim outcomes in future healthcare contract negotiations
- Ability to discuss any gaps in revenue cycle due to unpaid claims
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STEP FOUR: Collaboration and Communication
Collaboration is essential to the process
Identify trends, out-of-date policy, workflow improvements, staffing needs
Meet regularly to share ideas and discuss issues - include stakeholders at every level
Monitor and discuss outcomes
Evaluate execution to determine if as expected, discuss results with team
Communicate issues immediately with team to mitigate errors
Connect with experts in the field by participating in local and national associations
Resources must be up-to-date and monitored for changes
Establish accountability and ownership for critical components
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STEP Five – Determine an approach to appeals

Policies and Workflows

- Ensure policies and workflows are reviewed and updated on a predetermined basis
- Avoid the All or Nothing Approach
- Engage in every opportunity
- Create sound business practices that ensure success
- Determine what is to be appealed and to what level
- Make decisions based on an understanding of time and costs

Be Proactive - watch for policy changes and ensure proper execution from day one

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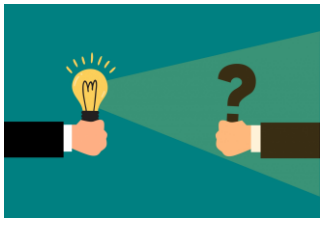
Q & A



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Helpful Terms

Amount in Controversy (AIC): The required threshold Level 3 and Level 5 appeal dollar amount still in dispute. CMS annually adjusts the AIC by a percentage increase tied to the consumer price index.

Appellant: A person or entity filing an appeal.

Determination: A decision on coverage and claim payment and liability.

Escalation: When an appellant requests to move a reconsideration pending at the QIC level (second level appeal) or higher to the next level because the adjudicator can't make a prompt decision or dismissal. The appeal must meet the applicable AIC Level 3 and Level 5 requirements.

Medicare Redetermination Notice (MRN): A MAC letter informing a party about the redetermination decision.

Non-Participating: Physicians and suppliers who haven't signed a Medicare participation agreement but may choose to accept or not accept Medicare assignment on a claim-by-claim basis. Non-participating physicians and suppliers have limited appeal rights.

Party: A person or entity with standing to appeal an initial determination or subsequent administrative appeal determination or decision.

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Thank You!

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