

Medicare: Administrative Appeal Process And Judicial Review

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By this time, virtually all medical providers are routinely providing services to Medicare beneficiaries who have opted to receive their benefits through an HMO. Major insurers have aggressively marketed these plans over the past several years and have been quite successful, resulting in the prevalence we now see of Medicare HMOs. Such marketing endeavors continue today, attracting more and more Medicare beneficiaries into these plans. Accordingly, this article will be devoted to a discussion of the provider's right to appeal delayed and/or denied claims for services, and the legal remedies which exist beyond an administrative appeal.

There are two types of procedures for resolving enrollee, i.e., beneficiary complaints. They are the Medicare appeals procedures and internal plan grievance procedures. The grievance procedures of an HMO plan are internal to the plan and are intended to primarily address quality of care issues. On the other hand, the Medicare appeal process is primarily designed to address complaints regarding the payment for services and/or the denial of services. As a practical matter, providers will almost always be concerned with payment for services already rendered, and occasionally with denial of authorization for requested services.

On April 30, 1997 HCFA adopted new rules setting forth an expedited appeals process for urgently needed services. HMOs, CMPs (Competitive Medical Plans) and (HCPPs) health care prepayment plans must render decisions within 72 hours of an enrollee's appeal of a denial-of-care decision when the health plan's adverse determination could seriously threaten the enrollee's life, health or maximum recovery. The rules were also modified to add discontinuation of services to the 72 hour ruling requirement. Additionally, the rules now provide that physicians and other health care professionals may act on behalf of an enrollee that is appealing an adverse determination; and health plans are now

required to accept the request of a physician, regardless of whether the physician is affiliated with the health plan, to expedite the process of making final ruling by the health plan. These rules became effective August 28, 1997.

Because of this relatively new role, there are many fewer adverse determinations at the initial stage of requesting services for an enrollee. Most HMOs are simply not well enough equipped to gather clinical data and make a ruling on a request for services within 72 hours. Rather than run the risk of non-compliance with the new 72 hour appeal rule, the plans opt to retrospectively deny payment for services on the basis of lack of medical necessity. The other method frequently employed is delay of payment while clinical information is gathered by the health plan so that it can make its final determination on a given claim. The upshot of this from the provider's perspective is much the same result that we see in workers' compensation cases - the patient gets their services, then the provider is left to deal with the aftermath of "cleaning up" the claim in order to obtain a payment from the health plan. To hopefully assist you with the inevitable, let us now analyze the health plan's obligations and the Medicare appeal process, as they exist today.

All risk-based and cost-based contractors must comply with the Medicare appeals procedures.

There are 5 levels of the Medicare Appeals Process

The 5 levels (or steps) in the Medicare appeals process are:

* Initial determination by plan; * Reconsideration determination; * Plan reviews its initial determination * HCFA contracted reconsideration agent reviews case if plan's decision is partially or fully against the beneficiary * Hearing by Administrative Law Judge (ALJ) if at least \$100.00 at issue; * Appeals Council Review; and * Judicial Review, if at least \$1,000.00 at issue.

The Health Plan's Deadlines

The plan is to issue a notice of the claim determination on all "clean" claims within 24 calendar days of receiving the claim. A "clean" claim is one which has no defect, impropriety or particular circumstance requiring special treatment preventing timely payment. For a non-clean claim, the plan is obligated by HCFA's HMO/CMP rules to issue an initial determination notice to the member within 60 calendar days of receipt of the claim for payment or request for services. Failure to issue a notice of claim determination, i.e., an RA, EOB or other suitable explanation, within 60 days constitutes an adverse initial determination, which may be appealed. In the event of an adverse initial determination, i.e., claim denial, notices of such must be forwarded to the enrollee and such notices must contain specific information about the appeals procedures. Also, the notice of adverse determination must contain the specific reason(s) for the denial. Generalized statements are unacceptable under the HCFA rules.

Parties to the initial adverse determination have certain appeal rights. Those parties are:

- * The enrollee; The legal representative on behalf of a deceased enrollee's estate; or,
- * Any other entity determined to have an appealable interest in the proceeding. (*This includes out-of-plan physicians and suppliers who are seeking reimbursement for items or services and who have formally agreed to waive payment from the enrollee for the item or service in question.*)

The Provider's Deadlines

Once the provider decides that it wishes to appeal a claim denied by a Medicare HMO, it must execute what is referred to as a "Waiver of Payment" form, which is described immediately above. The form (SSA 1696, U4, Appointment of Representative) is obtainable from a local Social Security Office. They may also be available from the HMO in question. This form should be included with the documents submitted in the provider's appeal. Please note, however, that the provision which allows the provide to proceed on a "Waiver of Payment" *does not* prevent the provider from being appointed as the designated representative of

the patient or the estate of a deceased enrollee. As a matter of practice, however, this author highly recommends that providers use only the "Waiver of Payment" approach and suggest to patients that they have a close relative act as their personal representative, or obtain legal counsel.

Appeals, also referred to as "requests for reconsideration", must be filed within 60 days of the date on the notice of adverse claim determination. For providers, this means the date on the remittance advice (RA) or explanation of benefits (EOB) received from the plan, indicating to the provider that the claim had been denied. This is really the provider's first level of appeal and this appeal is directed to the health plan and no other organization at this level. *Tip:* The author recommends that these appeals be submitted via certified mail, return receipt requested and that the person who submits the appeal be responsible for securing the certified mail delivery receipt and placing it securely in the provider's patient account file on the claim in question.

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NDG then must make its claim determination within 60 days and send notification of the same to all parties in interest, which includes the provider, if the provider initiated the appeal. NDG will either recommend payment, denial or partial payment, unless it is reviewing a request for services not yet rendered.

If the claim is not resolved to the appellant's satisfaction at that point, a party in interest may then request a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration (SSA). The HMO/health plan has no right to a further hearing if it was ordered by HCFA's reconsideration agent (NDG) to pay a claim and/or authorize certain services to an enrollee.

After proceeding through the ALJ hearing, if a party in interest remains unsatisfied, the claim can then be appealed to the Appeals Council of the SSA,

and yet again to the United States District Court, provided the amount in controversy is at least \$1,000.00.

Many providers should be able to resolve many of their own payment issues with Medicare HMOs through the first-level appeal procedure. If, however, that appeal is unsuccessful and the provider wishes to pursue its claim it may be wise to consider securing legal counsel, as there are exceptions to the rules and other variables encountered along the road to reimbursement, which are beyond the scope of this article - and also beyond the reasonable capabilities of the business services component of most health care institutions and organizations. Your author welcomes your comments and inquiries. Good luck with those appeals.