

PHYSICIAN ADVISOR SERVICES

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REVIEW OF MEDICARE APPEALS PROCESS

This article is a quick reminder of the Medicare Appeals Process. In January Medicare Learning Network published a brochure titled "The Medicare Appeals Process: Five levels to Protect Providers, Physicians, and Other Suppliers." The link to the document is <https://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>.

There are five levels of the Medicare Part A and Part B administrative appeals process that are available to all providers. The levels are:

- Redetermination by an FI (fiscal intermediaries), carrier or MAC (Medicare Administrative Contractors)
- Reconsideration by a QIC (Qualified Independent Contractors)
- Hearing by an ALJ (Administrative Law Judge)
- Review by the Medicare Appeals Council within the Departmental Appeals Board,
- Judicial review in U.S. District Court

First Level: Redetermination

"A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination." The

entity appealing has 120 days from the date of receipt of the initial claim determination to file an appeal. There is no monetary threshold required for this request.

Second Level of Appeal: Reconsideration

If the party to the redetermination is not satisfied with the outcome, they can request a reconsideration. A QIC will conduct the reconsideration. This process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. There is no monetary threshold required for this request.

Third Level of Appeal: Administrative Law Judge Hearing

This level does have a monetary threshold limit. If there is at least \$130 (the amount for 2011) that remains in dispute following the QIC decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration.

Fourth Level of Appeal: Appeals Council Review

The next level of appeal after the ALJ hearing is for the Appeals Council to review the

amount that remains in controversy. There are no monetary requirements at this level. The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision and must specify the issues and findings that are being contested. The Appeals Council will issue a decision within 90 days of receipt of a request for review. The timeframe may be extended for various reasons such as the case being escalated from an ALJ hearing.

Fifth Level of Appeal: Judicial Review in U.S. District Court

If after the Appeals Council review there is at least \$1,300 (the amount for 2011) still in controversy, a party may request judicial review before a U.S. District Court judge. The request must be filed within 60 days of receipt of the Appeals Council's decision.

The documentation from CMS says that the appeals process is established to protect providers, physicians and other suppliers. The appeals process can be cumbersome and many hospitals during the RAC Demonstration Program decided against appealing cases that may have been

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winnable. When cases get to the ALJ level of appeal the win rate is extremely high. However, most cases never reach that level. For example, for DRG 247 the appeals experience between 2008 and 2010 shows that of the 4,748 cases initially reviewed, 32.7% were paid. Of the cases going to the 1st level of appeal 16.5% were paid. For the third level, 4.2% were paid. At the ALJ level 97.4% of the cases were paid. But of the initial 4,748 cases, only 114

were reviewed at the ALJ level. It is a good practice to have a process in place that allows for a robust review of denied claims so that the decision to appeal or not can be made based upon a sound clinical judgment. Many times a physician advisor can effectively review the charts and give an opinion on whether the case should be appealed. Of course, the best defense is a good offense and that can be accomplished by having

processes in place to make a well documented determination while the patient is still in the hospital. For many facilities, a physician advisor program is an effective resource for facilitating the appropriate level of care. If you have questions on how to handle appeals or about physician advisor services, please contact Ann Purdy at 205-314-8859 or by clicking [here](#).

The link to The Medicare Appeals Process document:

<https://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>



ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

Region A-DCS

<http://www.dcsrac.com/IssuesUnderReview.aspx>

1-866-201-0580

Region B-CGI

<http://racb.cgi.com/Issues.aspx?st=1>

1-877-316-7222

Region C-Connolly Healthcare

http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx

1-866-360-2507

Region D-HDI

<https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx>

866-590-5598 (Part A)

866-376-2319 (Part B)

RAC FAQs - EXCERPTS FROM CMS WEBSITE

Under what circumstances can Recovery Audit Contractors (RAC) make a finding that an overpayment or underpayment exists without requesting medical records? RACs may use automated review (where NO medical record is involved in the review) ONLY in situations where there is certainty that the claim contains an overpayment. Automated review must:

- A) have clear policy that serves as the basis for the overpayment (“clear policy” means a statute, regulation, National

- Coverage Determination, coverage provision in an interpretive manual, or Local Coverage Determination that specifies the circumstances under which a service will ALWAYS be considered an overpayment);
- B) be based on medically unbelievable services; or
- C) occur when no timely response is received in response to a medical record request letter.

I am participating in a CMS demonstration. Are my

claims exempt from RAC review? At times CMS does grant temporary exemptions from RAC review for CMS sponsored demonstrations. However, all demonstrations do not get an exemption. The demonstration contractor or CMS will alert providers if their claims are exempt from RAC review during the demonstration. This alert can usually be found in the initial welcome letter. Questions can be directed to the contractor performing the demonstration.

To view all of the CMS RAC FAQs, click [here](#).

JOAN RAGSDALE NAMED FINALIST FOR B’HAM BUSINESS JOURNAL TOP CEO FOR 2011

Each year the Birmingham Business Journal features CEOs that are making a difference in their companies as well as the community. This year MedManagement’s CEO, Joan Ragsdale was selected as a finalist in the 25 to 100 employees category. Joan was selected as a result of the

expansion of the MedManagement footprint driven by the growth in Physician Advisor Services. Regarding the expansion she said, “growth trajectory is dependent upon us communicating what we do, how we do it and the value.” The employees of

MedManagement are delighted that Ms. Ragsdale was selected as a finalist and appreciate her leadership. As Henry Kissinger said, “the task of a leader is to get his people from where they are to where they have not been.” We are excited about the journey!