

MEDICARE: WHAT TO DO WHEN CLAIMS ARE REJECTED

By Orly Avitzur, MD, MBA

It is not news that the conversion factor used to calculate payment rates for individual services reduced payment levels by 5.4 percent from 2001 to 2002. The decline was a result of a flawed formula used to calculate the annual update in physician payment. As disturbing as this reduction is, much more alarming is the tendency for physician practices to leave money on the table when it comes to contesting Medicare denials.

According to *Medicare Part B News*, fiscal year 2000 data provided by Centers for Medicare & Medicaid Services (CMS) to the General Accounting Office for a June 11, 2001 report revealed that:

- 20 percent of all processed Part B claims were denied by Medicare;
- Only three percent of claim denials were appealed;
- Most appeals were resolved by a simple carrier review before being brought before a fair hearing officer;
- 47 percent of the claims that reached the carrier's fair hearing process were successfully overturned.

REDUCE DENIALS

So what can be done to address denials and prevent large income losses? Make sure your charts and HCFA forms are completed properly. Jim McNally, a former medical society ombudsman and principal of Health Care Consultant Services, says the Office of Inspector General (OIG) compliance guidelines make some key points about charts and HCFA forms that you may find obvious, but are still worth reviewing. He advises the following:

- Include the date, the provider's name, and the reason for the encounter;
- Confirm that the record supports the ICD-9 and CPT codes you are billing;
- Include the history, examination, test results, assessment, diagnosis,



Dr. Orly Avitzur is a neurologist in private practice in White Plains, NY.

- and plan of care;
- List risk factors, progress, as well as responses to and changes in treatment;
- Ensure that your record is legible; this is a key factor in carrier audits;
- Check to make sure all information regarding secondary coverage is entered on the claim form.

REFER TO MEDICARE GUIDELINES

Know your local carrier's policies and indications for covered services. One of the most useful tools Medicare offers (unlike most carriers) is the full disclosure of their covered services. It is important that billing and coding staff refer to Local Medicare Review Policies and know which services are considered a covered indication for the conditions you treat. Mr. McNally said the monthly bulletins and the local carrier Web sites are excellent sources for this information.

Saty Satya-Murti, MD, a neurologist and Medicare Medical Director for a

Blue Cross-Blue Shield contractor with CMS, agrees that there is an abundance of information on the Internet. (His carrier covers Kansas, Nebraska, and Western Missouri for Part B Medicare and Kansas for Part A Medicare.)

MEDICARE RESOURCES

The Health Care Financing Administration (HCFA) – the precursor to CMS – has a very well-developed site, www.hcfa.gov, which includes tools and resources for physicians, he said. Not all of the information from the HCFA site has been transferred to the new CMS Web site, www.cms.gov, so Dr. Satya-Murti suggested that neurologists refer to the former HCFA site for now.

The HCFA site includes the *Carriers Manual* Part Three Chapter XII, which describes the steps of the appeals process (See Chart 1).

In addition, a comprehensive repository of local medical review policies is posted at www.LMRP.net. This fully searchable national Web database offers links to the local policies and is a good source for comparing coverage criteria practices among contractors (carriers).

CMS's web site also lists recent national coverage decisions and the scientific rationale behind these determinations at www.hcfa.gov/coverage/8b3.htm.

BUILD RELATIONSHIPS WITH YOUR CARRIER MEDICAL DIRECTOR

J. Baldwin Smith, MD, a neurologist in Winston-Salem, NC, who is Chairman of the Health Policy Committee of the American Academy of Sleep Medicine, said, "Physicians need to get their attitudes straight when they speak to their local Medicare carrier office personnel."

The key is to listen and be open, and

to recognize that it is a two-way relationship. Neurologists should try to make their carrier's medical director their ally, Dr. Smith said, adding that the most successful approach is to ask what you can do to help.

Dr. Smith cited one case involving a patient who needed a CPAP machine replaced after 15 years. At that time, there was a carrier policy that mandated that a sleep study be performed with each replacement. Dr. Smith called the medical director and explained that this was not medically necessary in this case. By making that call, he saved the payer \$1,800, and he quickly made a new friend.

In another case, Dr. Smith arranged for the carrier to work with a vendor who supplied a far less expensive CPAP compliance meter by developing a loaner program. He believes that the carriers recognize integrity and are grateful to physicians who are working to help their patients.

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Dr. Satya-Murti agrees that there are benefits to maintaining a non-adversarial relationship with your carrier. "Although the appeals process cannot be short-changed, it can run in parallel with contact with the carrier medical director." He encouraged neurologists to write to their carrier's medical director if they feel a policy needs to be reconsidered.

HOW TO APPEAL DENIALS

Mr. McNally advises neurologists to carefully examine the claims being denied by your local carrier. "Do not write them off if you feel the claims are justified. While appeals can be expensive in terms of staff time and resources, if a carrier is incorrectly adjudicating claims, then an appeal is essential to alert the carrier to possible problems at their end. Too often, carriers point the finger at physician errors but it can be a two-way street. When CMS sees an increase in the volume of appeals, they will question the carrier because that increase might indicate a procedural problem. CMS believes that if the carrier's appeal volume goes up, either the providers are not being

CHART 1 — THE MEDICARE PART B FEE-FOR-SERVICE APPEALS PROCESS

<http://www.hcfa.gov/pubforms/14%5Fcar/3b12000.htm>

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD THRESHOLD TO BE MET
Review	6 months from date of initial determination	None
Hearing Officer (HO)	6 months from date of review determination	At least \$100 remains in controversy (at least \$100 for home health services)
Administrative Law Judge (ALJ) Hearing	Filed within 60 days of receipt of HO hearing decision	At least \$500 remains in controversy (at least \$100 for home health services)
Departmental Appeals Board (DAB) Review	None	Filed within 60 days of receipt of ALJ hearing decision /dismissal
Federal Court Review	Filed within 60 days of receipt of DAB decision or declination of review by DAB	At least \$1,000 remains in controversy

properly educated or the carrier is generating an inordinate number of claims through the appeals process perhaps due to a misunderstanding of the policy by their staff."

Mr. McNally added: "When even your appeal is denied and you are certain the claim is justified, ask for a fair hearing. CMS will also investigate an increase in the number of requests for this next level of appeal."

- **Appeal your denial to the first level internal carrier review.**

This should be performed in writing or by using a HCFA form 1964 (request for review). This form must be filed within six months of the date on the explanation of benefits. Be sure to attach the original claim and supportive documentation.

- **If the request for review fails, you may ask for a "fair hearing."**

The new regulations also allow reconsideration by a "Qualified Independent Contractor" within 180 days. These new entities use panels of physicians or other health care professionals and are not bound by the carrier's local medical review policies. (At press time, the new regulations were not yet in effect and their efficacy remains to be determined).

- **Know the time frames for submitting claims and appeals. (See Chart 1).**

Recognize and avoid services that are frequently denied, including: areas of billing that are clearly not reasonable and necessary; services not meeting the covered indication; and services that exceed frequency parameters. The frequency parameters are proprietary and are usually applied at the discretion of CMS; services exceeding a set number in any annual period will be denied. This problem often emerges with billing for electromyography and nerve conduction studies.

vices, they need to know the reason why. A proprietary database is used to determine the frequency of use per 1,000 patients and this is divided by the beneficiary so that neurologists, physiatrists, or other electrodiagnosticians who specialize in EMGs, for example, are not penalized."

Dr. Smith urges neurologists to be persistent when seeking appeals and "never give up." Like many others who have found the process to work fairly, he believes that sticking by your beliefs will ultimately pay off. ★

WEB RESOURCES

- ◆ Centers for Medicare and Medicaid Services, www.hcfa.gov
- ◆ Medicare Coverage Policy Decisions, www.hcfa.gov/coverage/8b3.htm
- ◆ Office of Inspector General, <http://oig.hhs.gov>
- ◆ HCFA Local Medicare Review Policy, www.lmrp.net
- ◆ Medicare Carriers Manual, www.hcfa.gov/pubforms/14_car/b00.htm
- ◆ Medicare Learning Network, www.hcfa.gov/medlearn/default.htm

FREQUENTLY DENIED SERVICES

Dr. Satya-Murti believes there are two sides to the problems of services that are frequently denied. "On one hand, there are physicians who bill for an unusually large number of services such as 10 motor nerves or perform atypical studies such as H-reflexes in unusual areas. On the other hand, there are Medicare carriers that do not understand EMG studies and have made statements that EMGs are not necessary if nerve conduction studies are performed."

Dr. Satya-Murti set up a table for his carrier describing the limits of services and statements that the symptom inclusion was sufficient. "Carriers are required to run data," he said. "If providers are always exceeding the limits of ser-

If you have additional questions about issues you'd like to learn more about or you would like to share how you are using technology in your own practice, please e-mail your ideas and questions to neurotoday@lww.com.