When Your Clients are Denied:

Helping Your Clients with Medicare Parts A and B Appeals

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What We'll Cover

- Background
  - The uniqueness of Medicare Parts A and B appeals
  - How Original Medicare Appeals Start
  - What Medicare denials will we cover?
- How to know when a Medicare Part A or B appeal is appropriate
  - Informal vs. formal remedies
- What must be done to get a Medicare appeal?
  - Denials or terminations of entitlement
- What is the role of benefits counselors?
  - Issue spotting
  - Making sure appeals are filed on time
  - Explaining options to your clients
  - Partnering with other community resources
- A review of routes to common types of Medicare Parts A and B appeals
- Case Studies
- Resources
- Next National Center for Benefits Outreach and Enrollment Training Webinar

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Background – The Uniqueness of Medicare Parts A and B Appeals

- In Original Medicare most coverage denials occur *after* the services have been provided
  - Appeals are usually about who will pay for services already received – issue is will Medicare pay or not
- But in some critical situations the issue can be whether Medicare will pay for more services
  - Examples include home health care, hospital care
- Perhaps the biggest issue for benefits counselors and your clients with Medicare denials, terminations, and reductions is figuring out that there is a problem and getting access to the applicable Original Medicare appeals process

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How Original Medicare Appeals Start

- Medicare-certified providers are required to submit claims for reimbursement.
  - But if Medicare providers do not believe Medicare coverage criteria are met, they are required to give your client a written notice warning them that Medicare could deny coverage and payment to the provider
  - Your client must go ahead and get the service to contest the provider's view on coverage
    - Because Medicare does not have an aid-paid-pending mechanism like most needs-based benefits, your clients may need to pay the provider for the service or care
    - If your client wins the appeal the provider must reimburse them and bill Medicare
  - Your client instructs the provider to submit a Medicare claim
    - Only after the service is provided, a claim is submitted and that claim is denied by the Medicare contractor (insurance company that processes Medicare claims), *then* your client can start an appeal

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How Original Medicare Appeals Start (cont.)

- Your clients usually discover that Medicare has been denied, or that coverage will be terminated or reduced via differing routes, depending upon the service
- For most Part B services for which the provider did not provide a prior notice of presumptive non-coverage, your clients will only find out when they get their quarterly Medicare Explanation of Benefits
  - The Medicare Summary Notice has easy-to-understand information on how to appeal and the deadline (usually 6 months) for submitting the request for the first level of appeal

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How Original Medicare Appeals Start (cont.)

- In most Part A cases (hospital, skilled nursing facility, and home health care), the provider must provide a prior notice before denying, terminating, or reducing Medicare coverage
  - If your clients want to *continue* to get a service that has been reduced or discontinued they must arrange for the service to continue, meaning they will have to:
    - Find a payment source for care after the effective date listed on the prior notice
    - Continue to meet any coverage criteria, including a physician's order
    - Receive the service and make sure the provider submits a Medicare claim
    - Start the appeal if the Medicare contractor (insurance company that processes Medicare claims) denies the continued coverage

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How to Know When a Medicare Part A or B Appeal is Appropriate

- First you need to have some familiarity with Medicare coverage criteria
- Next you need to know the facts of your client's situation
  - Compare the facts to the coverage criteria, and
  - If the facts suggest your client did meet the coverage criteria yet Medicare was denied, reduced, or discontinued, an appeal might be in order
- But remember that your client can only appeal from a denial of a service already received
  - And keep in mind that there is no "aid-paid-pending" in Medicare, following the effective date of a non-coverage notice there will be no more Medicare coverage and no more service delivery unless your client can arrange for services to continue and a Medicare claim to be submitted by the provider

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What is the Role of Benefits Counselors?

- Issue spotting
  - Understanding enough to be able to identify when a Medicare denial is inappropriate
  - Knowing what to do when you spot such an issue
    - What's the range of possible resolution strategies?
    - What are the consequences for your client?
- Making sure appeals are initiated in the correct way, and on time
  - There will be rules for how, when, and where to file the appeal
  - Know the deadlines for filing the appeal

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What is the Role of Benefits Counselors? (cont.)

- Explaining options to your clients
  - Your client "owns" the decision about how to proceed
    - Clients with substitute decision-makers
  - Be prepared to explain the options to your client to enable your client to make an informed decision
    - Even if you do not think the decision your client makes is wise
- Partnering with other community resources
  - Who in your community has expertise in Medicare appeals?
  - What if that "partner" is really busy?

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What Medicare Denials Will We Cover?

- Impossible to cover all kinds of Medicare appeals in one webinar!
- We will explore a sample of common types of Medicare denials, terminations, and reductions you may see:
  - Ambulance
  - Durable medical equipment
  - Doctor services
  - Hospital coverage
  - Home health care

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Medicare Appeals: Ambulance

- Your client will discover the denial though a prior notice (called an Advance Beneficiary Notice), or when she gets her quarterly Medicare Summary Notice and/or a bill from the ambulance company
- Step One: Gather all the documentation your client has and ask the ambulance company for their documentation too
  - This includes any prior notice the ambulance provider gave in a non-emergency situation
  - If a mistake was made in the claims process, ask the ambulance company to resubmit the Medicare claim
  - That could fix the problem!
- Step Two: Start the appeal if your client and you reasonably believe the coverage criteria for the ambulance ride in question were met
  - Follow the directions to get the appeal started within 120 days – request a Redetermination
  - You can help if you and your client have completed an Appointment of Representative form
  - Get response from Medicare contractor within 60 days

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Medicare Appeals: Durable Medical Equipment

- Your client will likely find out about a denial through a prior notice delivered by the durable medical equipment supplier
  - Called an Advance Beneficiary Notice
- Your client must arrange to:
  - Meet the coverage criteria for the specific equipment,
  - Find a coverage source,
  - Obtain the equipment from a Medicare-certified supplier,
  - And have the Medicare-certified supplier submit a Medicare claim.
- Your client will find out that Medicare coverage has been denied when he gets his quarterly Medicare Summary Notice
- Step One: Start the appeal by requesting Redetermination within 120 days
  - Get response within 60 days
- Step Two: Request Reconsideration from Qualified Independent Contractor (QIC) within 180 days
  - Get response within 60 days

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Medicare Appeals: Doctors' Bills

- Your client will likely discover a doctor's bill has been denied when she gets her quarterly Medicare Summary Notice
  - Advance Beneficiary Notices *should* be rare in the context of doctor services unless the doctor service is going to be very expensive
- Step One: You and your client should first review all the documentation your client has and ask the office manager or billing office at the physician's office about possible claims submission errors
  - If a mistake was made in the claims process, ask the doctor's office to resubmit the Medicare claim
  - That could fix the problem!
- Step Two: Request Reconsideration within 120 days of getting the Medicare Summary Notice
  - Get response from Medicare contractor within 60 days
- Step Three: Request Reconsideration within 180 days of adverse Redetermination notice
  - Get response within 60 days from Qualified Independent Contractor
- Step Four: Request Administrative Law Judge Hearing within 60 days of adverse reconsideration decision

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Medicare Appeals: Hospital Stays

- When your client with Medicare is admitted to the hospital:
  - The hospital must provide a notice called “Important Message from Medicare”
    - This notice explains how to start an appeal for more time if the hospital decides Medicare will no longer cover the stay
  - If the hospital decides to discharge your client before the client believes she is ready to leave, the hospital must give another copy of the “Important Message from Medicare”
    - This notice could be delivered as early as 2 days before the proposed discharge and as late as only 4 hours prior the proposed discharge
    - Step One: Your client must *call* the Quality Improvement Organization (QIO) that adjudicates emergency hospital appeals for Medicare no later than midnight of the day of the proposed discharge to start an Immediate Review
      - QIOs must be able to receive these calls 24/7

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Medicare Appeals: Hospital Stays (cont.)

- Step Two: The hospital must give a “Detailed Notice” to the client explaining the reason the hospital believes Medicare hospital coverage criteria are no longer met
- The individual can stay in the hospital and receive hospital care if the QIO rules in her favor (very rare), or
  - Until noon of the day after the day she gets an adverse decision from the QIO
  - The QIO generally makes its decision within 48 hours of the call by your client
  - She becomes liable for the cost of as of noon of the day following the adverse QIO decision
- Step Three: If she wants to appeal for Medicare coverage of staying in the hospital past the deadline, the next appeal is Reconsideration by the Qualified Independent Contractor (QIC)

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Medicare Appeals: Home Health Care (cont.)

- Complete termination of home health care:
  - Before completely stopping Medicare-covered home health care, a Medicare-certified home health agency must give your client a Notice of Medicare Provider Non-Coverage
    - This notice must be given to your client 2 days before services are stopped
  - Step One: Your client can ask for a fast appeal by calling the Quality Improvement Organization (QIO)
    - Your client must request a fast review no later than noon of the day before the services will stop
    - Step Two: If the QIO decision is negative, your client must find a way to pay to keep the services in place and ask the agency to submit a Medicare claim
    - The QIO will generally make its decision within 48 hours of the request
      - The QIO must ask your client why she believes services should continue
    - Step Three: If the claim is denied your client will find out when she gets her quarterly Medicare Summary Notice and can then ask for a Redetermination

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Medicare Appeals: Home Health Care

- Denial of care or reduction:
  - When a Medicare-certified home health agency declines to provide Medicare-covered care or decides to reduce your client's home health care, it must give your client a Home Health Advance Beneficiary Notice (HHABN) explaining when Medicare coverage will cease and why
  - Step One: If your client does not agree with the reduction, she can try to find another agency and ask the doctor to send a home health order to the alternative agency
    - She will have to find another payment source and convince the agency (or another agency) to continue the services
  - Your client must direct the agency to submit a Medicare claim
  - If the Medicare contractor agrees with the agency, the client will learn of the Medicare denial when she receives her quarterly Medicare Summary Notice and she can then request a Redetermination

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Other Medicare Appeals Considerations

- Distinguishing billing and claims completion errors or delays from coverage criteria issues that require an appeal
- Getting needed care after Medicare coverage is denied
  - Challenges you can help with – how to obtain a payment source pending the appeal, which would take months
- Amount in controversy
  - No right to an Administrative Law Judge (ALJ) hearing unless there is a designated amount of money at stake in the appeal
    - $130 in 2010
  - ALJ hearings are the third of the 5 levels of Medicare appeals and the level where your clients have the best chance for success
    - Most hearings are via telephone or teleconferencing

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Case Study

- Mrs. James is 56 years old and on Medicare because she has End-Stage Renal Disease. She is very frail and cannot sit up while being transported, so an ambulance has taken her three times a week to renal dialysis for the last 2 years.
- She has called your agency in a panic because today the ambulance driver gave her a notice saying she no longer qualified for the ambulance and would have to pay herself. She *needs* to get to dialysis and the ambulance won't wait a long time for her to make up her mind.
- **What should you and she do?**

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Case Study

- What to do ---
  - Call ambulance company ASAP and try to get your client appropriate transportation to dialysis
    - Call upon community legal advocacy partners for help
  - Prepare for an appeal:
    - Obtain, complete and submit Appointment of Representative form
    - Obtain all paperwork from the client and the ambulance company
    - Could this be a billing or claim submission error?
    - If denial is caused by a dispute about coverage criteria
    - Request redetermination
    - If decision is adverse, request reconsideration
    - If decision is adverse, request ALJ hearing

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Case Study

- Mr. Gonzales is recuperating from hip replacement surgery. He also has congestive heart failure and diabetes. He finds it hard to get around and hard to keep track of everything he needs to do to not get sicker.
- He's had a nurse coming in weekly, a physical therapist twice weekly and a home health aide three times a week. He is at risk for needing to be placed in a nursing home, in which case he'll have to apply for Medicaid.
- He has contacted you because on Tuesday the home health aide gave him a letter saying the nurse would come once more on Friday and that would be the end of his home health care because his condition is staying more or less the same and he isn't getting better.
- **What should he do?**

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Case Study

- What to do ---
  - Contact doctor who ordered the home health care
  - Negotiate with home health agency or find another agency willing to provide the care under Medicare
  - Request a fast appeal from the QIO
  - If denied, request expedited Reconsideration from QIC
  - If denied, is there another payment source to continue the home heal care? If yes:
    - Keep service going and request ALJ hearing

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Resources

- Chart of Original Medicare Appeals (CMS)
  http://www.cms.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf
- Your Medicare Rights and Protections (CMS)
  http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf
- Appointment of Representative form
  http://www.cms.gov/cmsforms/downloads/cms1696.pdf
- Medicare appeals forms
  http://www.medicare.gov/basics/forms/default.asp
- HHS Office of Medicare Hearings and Appeals
  http://www.hhs.gov/omha/
- CMS Information on Original Medicare Parts A and B appeals
  http://www.cms.gov/OrgMedFFSAppeals/

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Resources (cont.)

- Notice of Provider Medicare Non-Coverage
  - http://www.hwco.com/ASSETS/817FC1D896BA42DBB0A3FEA6D1EADA82/CMS10123.pdf
- Home Health Beneficiary Notice of Non-coverage (HHABN)
  - https://www.cms.gov/BNI/Downloads/CMSR296EnglishHHABN.zip
- Important Message from Medicare (Hospital Appeals)
  - http://www.cms.gov/BNI/Downloads/CMSR193.pdf
- Appointment of Representative Form
  - http://www.cms.gov/cmsforms/downloads/cms1696.pdf
- MyMedicareCommunity Forum to continue this discussion
  - www.mymedicarecommunity.com/showthread.php?t=4543

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Next Training

- **LIS in 2011 - September 2010 NCBOE Training**
- An overview of how this valuable benefit will work in 2011, as well as a look at the LIS redetermination and re-deeming processes that are happening this fall.
- Tentative dates:
    - Tuesday, September 21, 2010 at 2:00 PM EDT
    - Wednesday, September 22, 2010, at 2:00 PM EDT
    - Wednesday, September 29, 2010, at 2:00 PM EDT

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Questions/Comments?

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Visit us on the Web at: www.CenterforBenefits.org

Make use of www.MyMedicareCommunity.org

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