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Lessons Learned from the ALJ Experience

Ralph Wuebker, MD, MBA
Chief Executive Officer

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Agenda

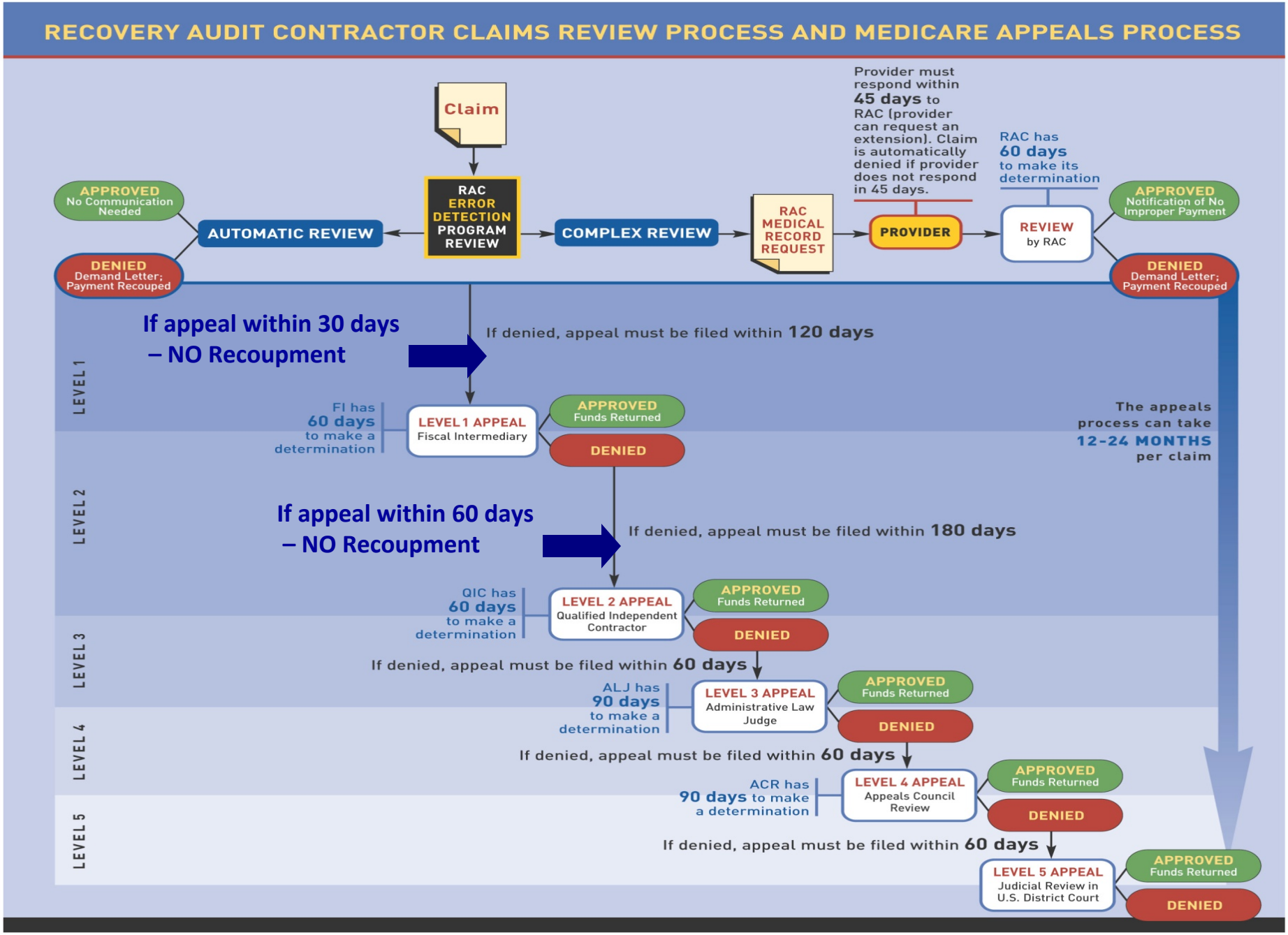
- ALJ Impact on IPPS
- Statistics
- Appeals Best Practices
- Key Takeaways

How to Win ALL Cases

The best way to overturn a denial is to prevent it.

When should the defense in an appeal/audit process begin?

When the patient walks in the door!


RECOVERY AUDIT CONTRACTOR CLAIMS REVIEW PROCESS AND MEDICARE APPEALS PROCESS
Claim
RAC ERROR DETECTION PROGRAM REVIEW
APPROVED No Communication Needed
AUTOMATIC REVIEW
DENIED Demand Letter; Payment Recouped
COMPLEX REVIEW
RAC MEDICAL RECORD REQUEST
Provider must respond within 45 days to RAC (provider can request an extension). Claim is automatically denied if provider does not respond in 45 days.
PROVIDER
RAC has 60 days to make its determination
REVIEW by RAC
APPROVED Notification of No Improper Payment
DENIED Demand Letter; Payment Recouped
If appeal within 30 days – NO Recoupment
If denied, appeal must be filed within 120 days
LEVEL 1
FI has 60 days to make a determination
LEVEL 1 APPEAL Fiscal Intermediary
APPROVED Funds Returned
DENIED
The appeals process can take 12-24 MONTHS per claim
LEVEL 2
If appeal within 60 days – NO Recoupment
If denied, appeal must be filed within 180 days
QIC has 60 days to make a determination
LEVEL 2 APPEAL Qualified Independent Contractor
APPROVED Funds Returned
DENIED
LEVEL 3
If denied, appeal must be filed within 60 days
ALJ has 90 days to make a determination
LEVEL 3 APPEAL Administrative Law Judge
APPROVED Funds Returned
DENIED
LEVEL 4
If denied, appeal must be filed within 60 days
ACR has 90 days to make a determination
LEVEL 4 APPEAL Appeals Council Review
APPROVED Funds Returned
DENIED
LEVEL 5
If denied, appeal must be filed within 60 days
LEVEL 5 APPEAL Judicial Review in U.S. District Court
APPROVED Funds Returned
DENIED

The Appeals Process…

Here is how the process is supposed to work:

- **Discussion (Not part of appeal process)** –
  - 40 days to file a discussion with the RAC (RAC Only)

- **Redetermination** –
  - 120 days to file an appeal with the Medicare Administrative Contractor
  - ***60 Days for MAC Response***
  - Overturn rate 7-9%

- **Reconsideration** –
  - 180 days to file an appeal with the Qualified Independent Contractor (QIC)
  - ***60 Days for QIC Response***
  - Overturn rate 12-19%

The Appeals Process…*(con't)*

- **Administrative Law Judge -**
  - 60 days to file an appeal with the Office of Medicare Hearings and Appeals
  - ***90 Days for ALJ Response***
  - Overturn 68-78 %
- **Medicare Appeals Council/Departmental Appeals Board –**
  - 60 days to file an appeal with the Departmental Appeals Board
  - ***90 Days for DAB Response***
  - Overturn rate 2-4%
- **Federal District Court –**
  - 60 days to file an appeal in Federal District Court

Who Are the ALJs

- Administrative Law Judges of the Office of Medicare Hearings and Appeals
  - Four field offices:
    - Southern (Florida)
    - Western (California)
    - Mid-West (Cleveland)
    - Mid-Atlantic (Virginia)
  - Central Docketing (Cleveland)
  - Answers to the Secretary of Health and Human Services, not to CMS
  - Hearings are usually conducted by telephone
  - Request to increase staff – not enough to address volume

ALJ Appeal Process

- The ALJ is bound by statutes enacted by Congress, regulations issued under the Act, rulings issued by CMS, and national coverage determinations in effect during the period at issue

- An ALJ should consider, but is not bound by, any other policy statements, instructions, and guidance issued by CMS, or by any local coverage determinations

- While not binding on the ALJ, these manual and policy sections are entitled to substantial deference (*Lyng v. Payne,* 1986)

Some Reasons for IPPS Changes

- **Overburdened Appeals Process**
  - Processing delays/escalation
  - ALJs were remanding many cases back to the QIC for determination of Part B payments
  - Questions regarding legitimacy of “Partially Favorable Decisions”
  - What decisions can appeals entities (MAC, QIC, ALJ) make regarding payment for care provided?

Key Elements of CMS 1455 NR (Interim Rule)

- Medicare review contractors are now subject to a limited scope of review - Part B payment cannot be considered during the review of a Part A claim
  - Appeals remanded from the ALJ to the QIC will now be sent back to the ALJ for review of the Part A claim
- Providers have the opportunity to rebill Part A claims
  - To rebill for Part B, hospitals must either withdraw their Part A appeals or no longer pursue an appeal of a denial of Part A services.
  - Rebilling is not subject to standard timely filing deadlines, but does have a rebilling timeframe – generally 180 days.
- Termination of the A/B Rebilling Demonstration Project

EHR's Observations From the Administrative Law Judge Level of Appeal

- Number of cases closed: 100k
- Number of cases in appeals process: 406,000
  - 336,594 = awaiting payer response + 70,065 = in process
- Dollars in waiting payer response: $ 2.4 billion
- Cumulative win rate: 95-97%

Top 10 Documentation Lapses

Instances That Impact Defensibility of a Decision During the Appeals Process:

1. No order in the medical record
2. Order is not consistent with billing
3. Order changed to Inpatient < 4 hours prior to discharge
4. No indication of an expectation of prolonged care (> 24 hours)
5. No indication of a continuation of severity of signs and symptoms
6. No reference to a concern about the predictability of an adverse event being high
7. No reference to the need for prudent testing at the time of evaluation
8. No evidence that the patients condition was threatened
9. Reference to “Admit to Observation” in the documentation
10. RN documentation conflicts with Physician documentation

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Best Practices for ALJ Hearings

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Three-Tiered Tactical Approach to Medicare Appeals

- All appeals should be designed to prepare for the ALJ
- Your argument must address three key components to have a high likelihood of success:
  - **Clinical:** Strong medical necessity argument using evidence-based literature
  - **Compliance:** Need to demonstrate a compliant process for certifying medical necessity was followed
  - **Legal:** Want to demonstrate, when applicable, that the Contractor has not opined consistent with the Social Security Act, the Medicare regulations or Medicare guidance.

Experience at ALJ Level of Appeal

- **Key observations from EHR's experience in the appeals process:**
  - ALJ hearings are as varied as the ALJs themselves
- The axiom: ***When you have seen one ALJ hearing, you have seen one ALJ hearing***
  - Different ALJs have different styles, and, as a result, often place different demands on the appellant
  - Preparation and experience are of paramount importance
- **NEW: 80% of contractors are having a physician or attorney attend the hearing – Statement of Work Requirements**

ALJ Variability Examples

- Syncope and the ear exam
- Dictator approach
- Personal experiences
- Expert witness (cardiologist)
- Hearing procedures (brief, noted page numbers, other)

Preparation of an ALJ Memorandum

- Recommend a detailed memorandum be prepared for the case and submitted to the ALJ prior to the hearing

- This memorandum should be composed of a thorough case review, detailed arguments regarding the medical necessity of care, and procedural arguments

Medical Necessity

- Explicitly detail why the care provided was medically necessary – tell a story
- Explain how the clinical judgment of the admitting physician is consistent with CMS guidance
- Provide evidence of utilization management, local and national standards of medical care, published clinical guidelines, and local and national coverage determinations

Lessons From the Experience

- It is best not to rely on a single procedural argument to win an appeal when the underlying medical necessity denial is unsound

- Challenge the validity of an unsound medical necessity denial with physician analysis while at the same time pursuing procedural remedies when applicable

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Best Practice Approach

- Good audit defense begins as soon as the patient comes into the hospital
- Demonstrate and document a consistently followed utilization review process for every patient to make a defensible admission decision
- Educate medical staff on documentation practices and make medical necessity decisions that are supported by clinical and regulatory evidence

OIG Findings Regarding the Administrative Law Judge Level of Appeal

Relevant Findings:

- ALJs reversed prior level decisions and decided fully in favor of appellants 56% of the time. **For Part A providers, the ALJs found fully favorable for the appellant 72% of the time;**

- The Differences in ALJ and QIC decisions were due to different interpretations of Medicare policies, the degree of specialization and the use of clinical experts. **Notably, the OIG states that ALJs tend to interpret Medicare policies "less strictly" than QICs and do not have medical directors or other clinicians on staff, as the QICs do. The OIG also reported that "ALJ and QIC staff commonly noted that some Medicare policies are unclear;"**

- CMS participated in only 10% of appeals and those appeals which CMS participated were less likely to be decided fully in favor of appellant (44% vs. 60% when CMS participated). **For Part A providers, however, there was no discernable difference – 59% when CMS participated and 62% when they did not);**

Source: Department of Health and Human Services, Office of Inspector General, "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals," November 2012, OEI-02-10-00340

OIG Recommendations Regarding the Administrative Law Judge Level of Appeal

Relevant Recommendations:

- Develop and provide coordinated training on Medicare policies to ALJs and QICs
- Identify policies, at least annually, that are unclear and interpreted differently by soliciting input from CMS contractors and ALJ staff and by analyzing appeals data
- Seek statutory authority to establish a filing fee
- Continue to increase CMS participation in ALJ appeals.

Source: Department of Health and Human Services, Office of Inspector General, "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals," November 2012, OEI-02-10-00340

Finally, OMHA

From an ALJ acknowledgement that we received after recently filing an ALJ hearing request:

"This office has been assigned your inpatient hospital claim. This letter is to inform you of our anticipated scheduling timeframe and claims processing requirements. Because of a very heavy and ever-expanding caseload of appeals arriving in our office, **we do not anticipate scheduling this case for hearing and decision until the last quarter of FY 2014. Many of the cases that we are receiving will not be heard and decided until the first and second quarters of FY 2015**. While the noted timeframe seems far in the future, it will provide time for the Appellant to comply with the attached Order. (emphasis added)"

So what does this mean?:

- Fiscal Year 2014 just started on October 1, 2013, placing the last quarter of FY 2014 from July-September 2014….just under a year wait just to have a hearing – but no decision!
- Once these hearing are actually held, a decision won't be rendered until sometime between October 2014 and March 2015….could be 1-2 years to get a decision

Key Takeaways

- If doing Medicare reviews, you should focus on the front end process. If you are focusing only on appeals, you have already lost
- Not all ALJs are created equal
- The best appeals address the clinical argument, reinforce your consistent process and follow the regulations
- Under IPPS for FY 2014, all reviewers, including the ALJ, are prohibited from addressing coverage under Part B
- It may take a long time to get through the appeals process!

Questions?

Ralph Wuebker, MD, MBA
Chief Medical Officer

rwuebker@ehrdocs.com

877-EHR-DOCS
www.ehrdocs.com
info@EHRDOCS.COM

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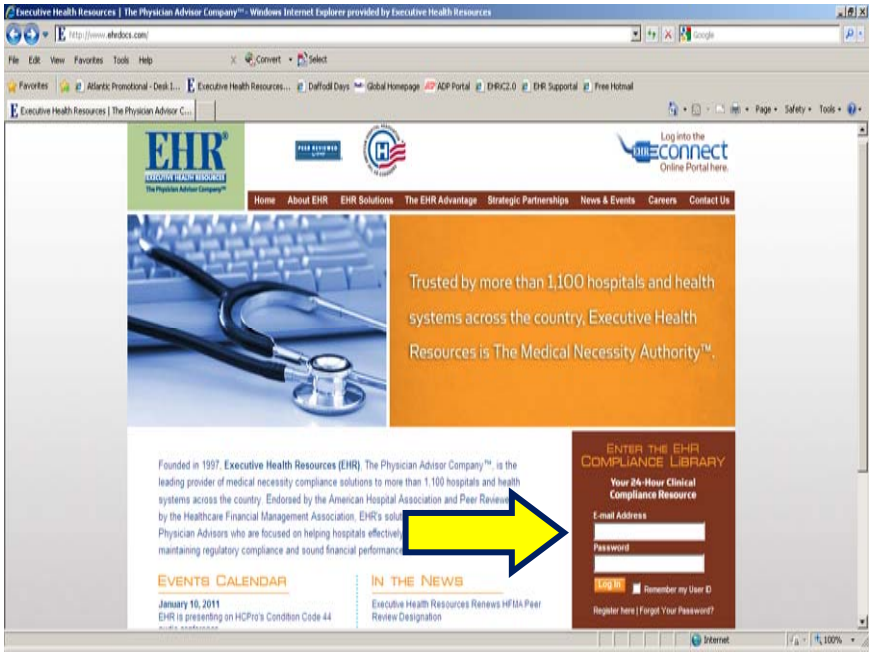

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About Executive Health Resources

EHR has been awarded the exclusive endorsement of the American Hospital Association for its leading suite of Clinical Denials Management and Medical Necessity Compliance Solutions Services.

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EHR received the elite Peer Reviewed designation from the Healthcare Financial Management Association (HFMA) for its suite of medical necessity compliance solutions, including: Medicare and Medicaid Medical Necessity Compliance Management; Medicare and Medicaid DRG Coding and Medical Necessity Denials and Appeals Management; Managed Care/Commercial Payor Admission Review and Denials Management; and Expert Advisory Services.

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EHR was recognized as one of the “Best Places to Work” in the Philadelphia region by Philadelphia Business Journal for the past five consecutive years. The award recognizes EHR’s achievements in creating a positive work environment that attracts and retains employees through a combination of benefits, working conditions, and company culture.

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