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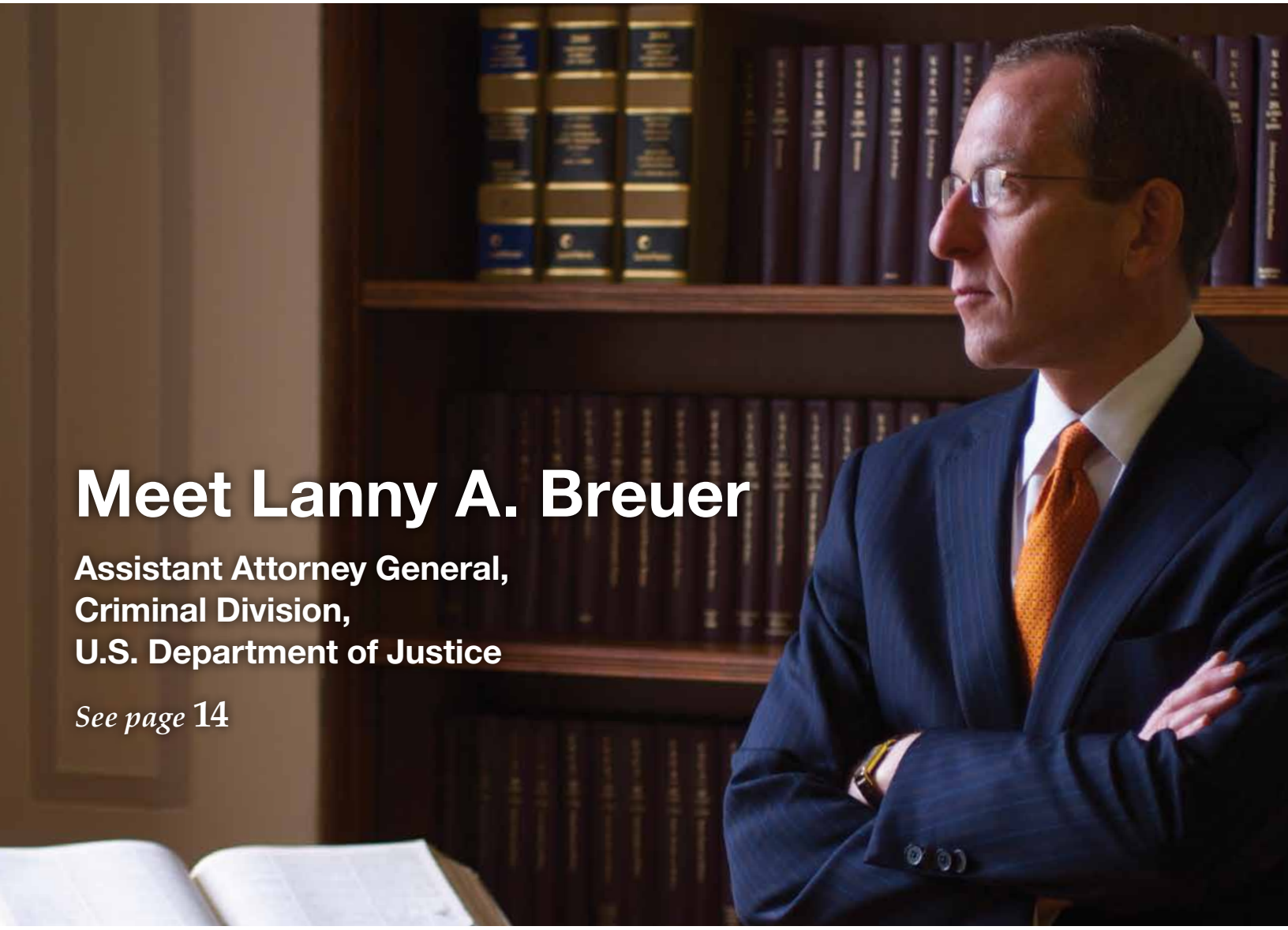

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DMEPOS reimbursement appeals and the compliance officer

» DMEPOS suppliers have five levels of Medicare claims appeals.
» DME MACs sometimes differ when interpreting the same Medicare rule.
» Suppliers should consider involving the Compliance department in claims appeals.
» Suppliers can draw on the Compliance department for reimbursement advice.
» Cooperation between Compliance and Reimbursement personnel can be a win-win.

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This article is the sixth in a series on DMEPOS compliance issues published in *Compliance Today*.

Among the many compliance concerns facing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, perhaps one of the most important is Medicare reimbursement and claims denials. After all, a well-developed referral network and satisfied patient base is of little value if the claims generated by those patients' orders do not get paid. With that in mind, DMEPOS suppliers should understand the levels of appeal available to challenge Medicare claim denials. Although the Medicare tiered appeals structure may at first seem intimidating, many DMEPOS suppliers are able to handle the first two levels of appeal in-house, drawing on outside legal counsel for those challenges that proceed to the third level of appeal and beyond.

Of particular benefit is when DMEPOS suppliers involve their compliance officer in the reimbursement appeals process. This involvement need not be extensive or significantly time-consuming. Simply by communicating with the Compliance department, suppliers can enjoy the resources of a subject matter expert on the pending appeals, while simultaneously keeping the Compliance department abreast of key claims denial areas. The compliance officer can use that information when conducting targeted audits and developing the supplier's annual compliance plan.


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Hot reimbursement issues

In the current enforcement environment, DMEPOS suppliers face a seemingly endless barrage of reimbursement challenges on state and federal levels. A significant hot issue regarding Medicare reimbursement denials is how to meet the medical documentation requirements for claim submissions. One approach suppliers can use to help decrease their denial rate is to employ staff with clinical backgrounds who can reinforce on appeal the reasons why a claim should be paid by Medicare, if the claim is denied. Another approach suppliers can consider to improve documentation of medical

necessity is to educate their referral sources on the Medicare documentation requirements so the referral sources can better document medical necessity in the patient records, thereby improving the supplier's chance of a clean claim submission and prompt reimbursement.

Another hot button challenge currently faced by DMEPOS suppliers is the inconsistent interpretation and application of Medicare regulations across the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Each DME MAC has an ability to issue its own rules or Local Coverage Determinations, but the DME MACs must also follow the CMS-issued rules applicable to all DMEPOS suppliers nationwide. However, there are times when the four DME MACs differently interpret the same CMS-issued rules, which results in inconsistency across the four jurisdictions. This challenge is more significant for suppliers operating nationwide and who must interact with multiple DME MACs.

An example of this challenge arises in medical necessity documentation and proof of delivery documentation. Some DME MACs adopt a narrow interpretation of the requirements, while others have slightly differing positions. For example, some DME MACs accept a download from mail carriers such as the United States Postal Service, whereas other DME MACs do not. As a result of regional inconsistencies, DMEPOS suppliers must create separate and unique processes to satisfy the requirements for each of the four DME MACs. A supplier's compliance officer can play an integral part to help the supplier's reimbursement personnel understand and coordinate among the varying interpretations across the DME MACs.

DMEPOS claims appeals process

Medicare uses a tiered appeals process, affording DMEPOS suppliers five levels of appeal to challenge denied claims. Each level has its own unique characteristics and requirements. Overall, once a DME MAC makes an initial determination to deny a claim, a supplier has the right to an appeal. All appeals must be made in writing. For most levels, the supplier can itself file the appeal, but many choose to retain legal counsel around the third or fourth level. Below is a brief description of the five levels of appeal.

First level — Redetermination

The first level of appeal is conducted by the DME MAC itself (but by a person other than the one who made the initial determination to deny the claim). A supplier must file the redetermination request within 120 days from the date of receipt of the initial determination. Suppliers can use form CMS-20027 to request the redetermination in writing, and should attach all supporting documentation to that request. The DME MAC will issue its decision within 30 days of receiving the supplier's reconsideration request.

Second level — Reconsideration

The second level of appeal is conducted by the qualified independent contractor (QIC). The QIC for DMEPOS suppliers is RiverTrust Solutions. A supplier that wants to appeal an unfavorable redetermination must file the reconsideration request within 180 days from the date of receipt of the unfavorable Medicare redetermination notice. Suppliers can use form CMS-20033 to request the reconsideration in writing and should attach all supporting documentation to that request, including the unfavorable Medicare redetermination notice. It is particularly important to include all supporting documentation at the reconsideration level because, without good cause, a supplier will not be able to provide any additional documents for review at subsequent levels of appeal. (This rule does not apply to witness oral testimony

given at the third level of appeal.) Generally, the QIC will issue its decision within 60 days of receiving the supplier's reconsideration request. If the QIC cannot complete the decision in that timeframe, the supplier may escalate the appeal to the third level.

Third level — Administrative law judge

The third level of appeal is a hearing before an administrative law judge (ALJ) in the Office of Medicare Hearings and Appeals. If at least $130 remains in controversy, a supplier may seek an ALJ hearing by filing a written appeal using form CMS-20034A/B (and may also file supplemental legal briefs). A supplier that wants to appeal an unfavorable reconsideration decision must file the request for an ALJ hearing within 60 days from the date of receipt of the unfavorable reconsideration decision. A supplier can request an in-person hearing, but hearings typically occur by videoconference or telephone. Suppliers can also forgo a hearing and instead ask the ALJ to issue a decision on the written record. Generally, the ALJ will issue its decision within 90 days of receiving the supplier's hearing request, but this deadline is often extended. If the ALJ does not issue a decision in that timeframe, the supplier may escalate the appeal to the fourth level.

Fourth level — Medicare Appeals Council

The fourth level of appeal is a review by the Medicare Appeals Council (MAC). There are no requirements regarding the amount in controversy. A supplier may seek MAC review by filing a written appeal using form DAB-101 and may also file supplemental legal briefs. A supplier that wants MAC review of an unfavorable ALJ decision must file the request within 60 days from the date of receipt of the unfavorable ALJ decision. Generally, the MAC will issue its decision within 90 days of receiving the supplier's request, but this deadline may be extended. If the MAC does not issue a decision in that timeframe, the supplier may escalate the appeal to the fifth level.

> The knowledge, experience, and ability of compliance officers to understand and interpret Medicare regulations allows them not only to highlight the hot Medicare reimbursement issues, but also to recommend solutions.

Fifth level — Judicial review in federal district court

The fifth and final level of appeal is judicial review by a federal district court judge. If at least $1,350 remains in controversy (for calendar year 2012), a supplier may seek judicial review by filing a written request in federal district court. The amount-in-controversy requirement increases each year. A supplier that wants judicial review of an unfavorable MAC decision must file the request within 60 days from the date of receipt of the unfavorable MAC decision.

Benefits of compliance officer involvement

Not all compliance officers of DMEPOS suppliers are involved with the claims appeal process, but those suppliers that do involve their compliance officers can realize some additional benefits. For example, by making the compliance officer aware of the types of claims being denied (and the reasons therefor), the compliance officer can integrate those denials into the supplier's annual compliance plan and compliance audits. In addition, the compliance officer can serve as a resource to

the reimbursement team on specific subject matter expertise. This is particularly useful to address rule inconsistencies across the four regional DME MACs.

The knowledge, experience, and ability of compliance officers to understand and interpret Medicare regulations allows them not only to highlight the hot Medicare reimbursement issues, but also to recommend solutions. In this manner, the compliance officer can serve as a bridge of communication between the organization, Medicare, and the DME MACs.

It is important that suppliers keep their compliance officers involved in the appeals process because compliance officers can track and trend claim denials and assist in efforts to demonstrate the frequency of the varying interpretations of Medicare regulations across the four DME MACs. By doing so, the compliance officer can align the supplier's focus with that of Medicare, allowing the organization to react proactively to any issues that may arise.

Conclusion

For some DMEPOS suppliers, the Medicare appeals process may seem to be an impenetrable, confusing morass. For other suppliers, the appeals process may appear routine, mundane, and simply a cost of doing business. Whatever a supplier's comfort level with the appeals process itself, suppliers who involve their Compliance department in the appeals process (at least to a degree), may reap some useful rewards in enhanced communication, reduced claim denial rates, and improved appeal success rates. Ultimately, this cooperation between the supplier's Compliance and Reimbursement departments can be a win-win for everyone at the organization.