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Proving That Beneficiaries Were Told of Appeals May Slow Decisions

At least one administrative law judge is requiring hospitals to produce evidence they informed beneficiaries when they appeal claim denials. The requirement delays the resolution of the case because the ALJ won't schedule a hearing until the hospital proves the beneficiary is in the loop, compliance officials say.

The requirement to send beneficiaries a copy of an ALJ hearing request is nothing new. It debuted in a 2005 interim final regulation and was finalized in 2009, an HHS spokesperson says. "Legally beneficiaries have a right to participate in the ALJ hearing," notes Denise Wilson, director of training and education for Denial Research Group AppealMasters in Luthersville, Md. But the request for proof, which wasn't enforced until recently, is holding up appeals and increasing costs, says Colleen Dailey, clinical coordinator of defense audits at WellSpan Health in York, Pa.

WellSpan received a letter from the Miami-based Office of Medicare Hearings and Appeals saying the appeal paperwork wasn't quite up to snuff. ALJ Jane Van Duzer wrote that WellSpan's request for a hearing on multiple claim denials would not be scheduled until WellSpan submits "written proof " that beneficiaries know about it. "For example, send the ALJ a copy of the documentation you sent to each beneficiary, along with one of the following: a copy of a signed, certified mail receipt; a copy of a signed delivery confirmation ticket; or a statement with the name and address of the beneficiary, along with documentation showing the date you forwarded the copy of the appeal request to the beneficiary," the ALJ wrote.

In response, Dailey, who says beneficiaries are always informed of appeals by WellSpan, has been resending the beneficiary letter by certified mail. That increases postage costs because ALJs don't accept appeals electronically (although documentation can be submitted on CDs). "It baffles me," Dailey says. "The beneficiary is not involved with this. They couldn't care less." And notifications may backfire, with the beneficiary or a family member getting upset because they think the appeal means they might get stuck with the hospital bill. Beneficiaries also may be hard to track down because they died or moved to nursing homes during the time that claims were audited, denied and appealed, Dailey says.

Other hospitals have received requests for proof of beneficiary notification, which is mostly coming from the Miami ALJ region, says Steven Greenspan, vice president of regulatory affairs at Executive Health Resources in Newtown Square, Pa. "We have seen judges dismiss cases because they didn't provide proof the beneficiary was sent the [notification]," he says. He thinks the focus on beneficiary notification is motivated by the desire to get through the docket faster. ALJs are swamped with appeals of medical necessity and other claim denials by recovery audit contractors. Requesting more paperwork buys them time to address the hospital's request for a hearing. Some ALJs send hospitals a checklist to indicate what's missing from hospital requests for a hearing, which could also serve as a way to double-check that your submission is complete (see box, below).

The 2009 final regulation requires a notice of hearing to be sent to all parties to an appeal (see 42 CFR Sec. 405.1020(c)). Hospitals and beneficiaries alike are parties to the initial claim determination and subsequent appeals, the HHS spokesperson says (see 42 CFR Sec. 405.906(a)(1) and (b)(1)). "The appellant must also send a copy of the request for hearing to the other parties," according to the regulation (70 FR 11420).

The HHS spokesperson says the Office of Medicare Hearings and Appeals will base its decision to ask for proof of beneficiary notification partly on whether beneficiaries were copied on appeals to qualified independent contractors (QICs), which is a step below ALJs. The notice of reconsideration in a QIC case must be sent to "all parties at their last known address" unless the overpayment determination involves multiple beneficiaries with no liability, the spokesperson says (see 42 CFR 405.976(a)).

The regulation doesn't dictate a method for demonstrating that beneficiaries were copied on appeals. "We are aware the administrative law judges may give examples of what may evidence delivery of the required copy, but it does not appear they are requiring specific forms of proof (e.g., a certified mail return)," the HHS spokesperson says. "However, we are listening to our

appellant community and will explore whether guidance to OHMA staff and appellants is necessary to ensure the regulation is being effectuated as intended and applied consistently across the agency."

While it's true that some beneficiaries don't care about the status of claims filed on their behalf, "others do have an interest," the HHS spokesperson says. It may affect their pocketbook; hospitals that lose appeals of Part A claim denials have to refund the deductibles to beneficiaries.

If beneficiaries have died in the interim, a copy of the request for a hearing "may be sent to the estate or a person obligated to make payment or entitled to receive payment," the HHS spokesperson says.

Greenspan finds it interesting that while providers have to notify the beneficiary that they have filed an appeal request, judges are not required to provide notice to the beneficiary that they are going to hold a hearing. "In addition to the administrative burden this would place on the law judges, it appears that a fair number of cases are adjudicated without hearing because of the strength of the documentation alone," he says. "You can only do that if the paperwork is strong enough."

Auditors Should Start at the Beginning

Even if documentation supports the claim, auditors may not focus on the patient's story up until the time of admission, Greenspan says. "We understand that many reviewers start with a review of the discharge summary when this document should actually play no role in the admission decision unless it supports the decision in accord with Chapter 1, Section 10 of the *Medicare Benefit Policy Manual,"* he says. "Reviewers should start their review with the initial triage notes and H&P and then work their way through the course of treatment up until the time of admission. "

And it's preferable if documentation supports the service provided instead of defending it, Greenspan says. Suppose a 53-year-old male presents at the emergency room with chest pain, pressure in his chest and sweatiness. "Upon evaluation the physician elicits that this guy is of normal weight (no obesity), regularly plays tennis and cuts the grass, and has no comorbidities that might impact his condition. Here the patient appears to be at low risk, but is of the age where there might be a cardiac issue," he says. The physician orders a full cardiac workup and documents "possible angina, could be esophagitis." No evidence of a cardiac problem emerges from the workup. On the discharge summary, the physician writes "extensive cardiac workup despite low risk and low index of suspicion."

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Using an ALJ Checklist to Improve Appeals

This checklist was attached to an administrative law judge's letter to a hospital requesting more documentation before scheduling a hearing. It could be used by hospitals to double-check that they have included all relevant materials in their appeals.

CONTENT REQUIREMENTS FOR THE REQUEST FOR ALJ HEARING

A review of your request for ALJ hearing shows that you did not include the following information:

___ the name of the beneficiary whose claim is being appealed;
___ the address of the beneficiary whose claim is being appealed;
___ the Medicare health insurance claim number of the beneficiary whose claim is being appealed;
___ the name and address of the appellant, when the appellant is not the beneficiary;
___ the name and address of the designated representatives if any;
___ the document control number assigned to the appeal by the QIC, if any;
___ the dates of service;
___ the reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed;
___ a statement of any additional evidence to be submitted and the date it will be submitted.

NOTICE REQUIREMENTS FOR THE REQUEST FOR ALJ HEARING

___ A review of the record shows that you did not send a copy of the request for hearing to the other parties. There is no evidence in the record that you sent a copy of the request for hearing to each beneficiary.
___ You submitted a request for hearing using CMS Form 20034-A/B U3, which instructs an Appellant to send a copy of the request for hearing to the other parties. While you checked the box indicating "Yes," on the form, there is no evidence in the record that you, in fact, sent a copy of the request for hearing to each beneficiary.