The How-To Manual for Rehab Denials and Appeals

Navigating the Medicare Process

Part of HCPro’s How-to series for therapists!

The How-To Manual for Rehab Denials and Appeals is part of the best-selling How-To Series which includes The How-To Manual for Rehab Documentation.

The How-To Manual for Rehab Denials and Appeals is a reliable, concise reference to help you navigate the denial and appeal process for Medicare therapy claims. This easy-to-use guide will help you understand the recent changes to the appeal process and give you advice and tips on how to appeal a Medicare claim within these new guidelines. It also covers stumpers like common denial reasons and how to prevent them, how to write an effective appeal letter, and how to testify convincingly before an administrative law judge.

About HCPro
HCPro, Inc., is the premier publisher of information and training resources for the healthcare community. Our line of products includes newsletters, books, audioconferences, training handbooks, videos, online learning courses, and professional consulting seminars for specialists in rehab, health information management, compliance, accreditation, quality and patient safety, nursing, pharmaceuticals, medical staff, credentialing, long-term care, physician practice, infection control, and safety.

Visit the Healthcare Marketplace at www.hcmarketplace.com for information on any of our How-To Manuals.
Contents

Acknowledgements .................................................. vii

About the Author ...................................................... viii

Chapter 1: Introduction .............................................. 1
  Major interim final rule changes ................................. 4
  Medicare Part A and the FI ................................. 5
  Medicare Part B and the FI and carriers .......................... 5
  Summary .......................................................... 6

Chapter 2: Common denial reasons ................................. 7

Stop denials before they start ....................................... 9
  Denial reason: No valid order .................................. 10
    Common denials due to lack of valid physician orders ............ 11
    Strategies to avoid denials like these ..................... 12
  Denial reason: Insufficient information ......................... 13
    Common denials due to insufficient information ............... 14
    Strategies to avoid denials like these ..................... 15
  Denial reason: No documentation to support services were rendered .... 15
    Strategies to avoid denials like these ..................... 16
  Denial reason: Therapy services were not reasonable and necessary .... 18
    Strategies to avoid denials like these ..................... 18
  Denial reason: Establishment of a maintenance program, home exercise
    program or self-management program .......................... 21
    Strategies to avoid denials like these ..................... 22
  Denial reason: Services should be billed with appropriate HCPCS codes ...... 23
    Specific codes to use ........................................ 23
# Table Of Contents

To appeal or not to appeal ........................................... 24  
Make it a teaching moment ......................................... 25

Chapter 3: The appeals process ................................. 27

Two categories of denials ........................................... 29

Appointment of Representative (AOR) ......................... 30

Assignment of benefits .............................................. 35

Initial determinations ............................................... 35

Levels of appeal ..................................................... 38
  Redetermination .................................................. 39  
  Appeal filing deadline .......................................... 40  
  CMS Form 2649 .................................................. 43  
  CMS Form 1964 .................................................. 43  
  Reconsideration .................................................. 47  
    Deadline for filing an appeal ................................ 48  
    CMS Form 1965 ................................................ 48  
    Administrative law judge (ALJ) hearing .................... 51  
    Checklist for ALJ level of appeal ............................ 53  
    Department of appeals board (DAB) ......................... 53  
    Federal District Court ........................................ 59

Chapter 4: Writing an effective appeal letter ................. 63

When to write an appeal letter .................................. 65

iv  The How-To Manual for Rehab Denials and Appeals: Navigating the Medicare Process
# Table Of Contents

**Format of a successful appeal letter** ........................................... 66
  Parts of the appeal letter ......................................................... 67

**Summary** .................................................................................... 70

**Chapter 5: Certification and recertification** ............................... 75

**Preparation is the key** ............................................................... 77

  Case preparation ........................................................................... 77
  Patient name .................................................................................. 79
  Claim denial dates ......................................................................... 79
  Medical diagnosis .......................................................................... 79
  Patient’s condition prior to therapy .............................................. 80
  Reason for hospitalization or need for therapy services ............... 81
  Overview of condition during evaluation ....................................... 81
  Goals set during initial evaluation and rehab potential ................. 82
  State why the patient needed therapy services ............................. 83
  Identify applicable Medicare criteria ............................................. 84
  Summarize the therapy services ................................................... 85
  Additional ALJ preparation notes .................................................. 85
  Summary ....................................................................................... 87

**Chapter 6: Make the most of your medical review process** .......... 89

**Benefits of a tracking system** .................................................... 91

**Tracking the claim information** .................................................. 92

**Use your medical review process information** ............................ 92
Table of contents

Chapter 7: Documentation strategies to prevent denials ........... 99
  ICD-9 coding keys to success ....................................... 101
  CPT coding keys to success .......................................... 103
  Establishing prior condition ......................................... 104
    Establishing prior level of function .............................. 104
    Goal writing .......................................................... 104
  Documenting balance .................................................. 106
  Are the essential elements present? ................................ 106
  Be proactive ............................................................ 108
Introduction

CHAPTER 1
Introduction

Denials and appeals happen to everyone

If you are a provider of therapy services, you will inevitably have to deal with the Medicare denial and appeal process at some point in your career. The level of interaction will vary based upon your setting; however, a thorough knowledge of the process is always the key to recovering the reimbursement that you have earned by providing services.

On March 8, 2005, Congress published an interim final rule in the Federal Register that outlines revisions to the appeals process. As with most aspects of understanding Medicare regulations, the premise remains the same: He who knows the rules of the game knows how to play the game. In purchasing this book, you have taken the initiative to expand your knowledge and learn the new rules of the Medicare denials and appeals process.

The changes to the process are significant and will require providers to perform parallel procedures for a time until the claims under the previous process have cleared the system and all claims submitted follow the updated process.
**Introduction**

**Medicare Part A and the FI**

Title XVIII of the Social Security Act provided health insurance for the aged and disabled in 1965, and this health insurance benefit is administered by the Centers for Medicare & Medicaid Services (CMS). The agency was formally known as HCFA, the Health Care Federal Agency, until 2001, when it changed its name to CMS. The Social Security Administration and the Railroad Retirement Board handle Medicare Part A and Part B enrollment.

CMS has contracts with public and private agencies called FIs and carriers to help it administer the Medicare program. FIs process Medicare Part A and Part B claims for providers that are facilities. Examples of facilities that use FIs are

- skilled nursing facilities (SNFs)
- home health agencies
- comprehensive outpatient rehabilitation facilities
- outpatient therapy in a hospital setting
- rehab agencies
- hospitals
- inpatient rehabilitation facilities

Medicare A insurance covers healthcare in several environments including

- inpatient care in hospitals
- inpatient care in SNFs
- home healthcare
- hospice care

**Medicare Part B and the FIs and carriers**

Carriers only process Part B claims and serve as contractors for noninstitutional providers. Examples of noninstitutional providers include private practice or independent practices of

---

The How-To Manual for Rehab Denials and Appeals: Navigating the Medicare Process 5
Chapter one

- physicians
- therapists
- laboratories
- suppliers

Medicare Part B covers healthcare in several environments including

- physician services
- nonphysician services
- physical, occupational, and speech-language therapy
- durable medical equipment (DME)
- ambulance transportation
- clinical laboratory services
- diagnostic tests

**Summary**

In this book you will find information about appeal levels and how to successfully navigate them. In addition, you will learn common reasons for denials and how to avoid them, strategies for successfully appealing a claim, documentation to support an appeal, and techniques to track and learn from denials at your facility.

Understanding the denials and appeals process for Medicare claims is a complex and challenging process. I hope that this book is a helpful resource and reference for you and your staff as you engage in this process.
Chapter one

**Major interim final rule changes**

- A uniform appeal process for both Part A and Part B claims.

- Revised time frames for filing requests for appeals of Part A and Part B claims.

- Additional information added to appeal notices for redetermination, reconsideration, and administrative law judge (ALJ) levels to assist and provide guidance for pursuing appeals.

- A 60-day time frame for redetermination decisions from carriers and fiscal intermediaries (FIs).

- Defined time frame for completion of appeals at the ALJ and department appeals board level

- Introduction of qualified independent contractors (QICs), which are entities that will reconsider redeterminations. The rule also includes a 60-day time limit for QICs to issue decisions and allows providers to request escalation of the appeal to the ALJ if a decision is unable to be made within 60 days.

- ALJ hearing threshold amounts will now be adjusted annually according to the Consumer Pricing Index for urban consumers to correspond with fluctuations.

- Providers may appeal a claim after a beneficiary dies.

Before delving into the intricacies of the appeal process, understand some basic information regarding Part A and Part B and the roles of carriers and FIs.
Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit www.hcmarketplace.com. If you received a special offer or discount source code, please enter it below.

<table>
<thead>
<tr>
<th>Title</th>
<th>Price</th>
<th>Order Code</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Your order is fully covered by a 30-day, money-back guarantee.**

**Enter your special Source Code here:**

- Name
- Title
- Organization
- Street Address
- City  State  ZIP
- Telephone  Fax
- E-mail Address

**BILLING OPTIONS:**

- [ ] Bill me  [ ] Check enclosed (payable to HCPro, Inc.)  [ ] Bill my facility with PO # ________________________
- [ ] Bill my (✓ one):  [ ] VISA  [ ] MasterCard  [ ] AmEx  [ ] Discover
- Signature  Account No.  Exp. Date

(Required for authorization)  (Your credit card bill will reflect a charge from HCPro, Inc.)

**Your order is fully covered by a 30-day, money-back guarantee.**

**Shipping Information**

- Please include applicable shipping.
- For books under $100, add $10. For books over $100, add $18. For shipping to AK, HI, or PR, add $21.95.

**Tax Information**

- Please include applicable sales tax.
- States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV.
- State that taxes products only: AZ.

Order online at www.hcmarketplace.com

Or if you prefer:

- MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945
- CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787
- FAX THE COMPLETED ORDER FORM TO: 800/639-8511
- E-MAIL: customerservice@hcpro.com

© 2008 HCPro, Inc. HCPro, Inc. is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks. Code: EBKPDF