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Successfully navigating the Medicare enrollment appeals process

The Medicare enrollment process represents one of the federal government's primary lines of defense against health-care fraud. Although the process has existed in one form or another since Medicare's inception, in recent years it has now become a tool of the offense in denying access to those who would pilfer from the Medicare Trust Fund.

Unfortunately, for everyone else, otherwise well-meaning physicians can and do get caught in the tangled web that is the enrollment process, both at initial enrollment and in terms of maintaining enrollment.

PURSUING AN APPEAL

If you run afoul of this system, you can appeal the final determinations of your status as a Medicare contractor, such as a denial or revocation of billing privileges, or when the effective date of such privileges is later than the physician expected. However, the appeals process itself can be daunting and fraught with potential snares. This article provides some background on the Medicare enrollment appeals process and explores some of the difficulties you can face.

The appeals process first becomes available to you after receiving a "final determination" from a Medicare administrative contractor (MAC). At this point, you may appeal the determination to the MAC by requesting a reconsideration. If the MAC rules against you, you may appeal the ruling to an administrative law judge (ALJ). If the ALJ rules against you, you may appeal to the Departmental Appeals Board (DAB). If the DAB rules against you, the decision may be appealed to federal court.

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Medicare will ask about 750,000 physicians and more than 1.4 million healthcare professionals to revalidate their enrollment records by 2013. To learn more about this anti-fraud campaign, see MedicalEconomics.com/Medicareenrollment

However, pursuing an appeal is not a simple affair; rather, it is a rigid, formal process where at each step, you must adhere to certain timeframes and requirements.

TIGHT TIME CONSTRAINTS

In general, at each step of the way, you have 60 days from the date of the letter notifying you of your appeal rights to submit an appeal. This clock is ticking even if you are otherwise in communication with the MAC, attempting to resolve the matter outside of the appeals process.

If the matter is not otherwise resolved within that 60-day window, you cannot then appeal; the window within which you can appeal is not open or extended merely because you are in communication with the MAC. A better course of action is for you to file an appeal even while also attempting to resolve the matter informally. This course will, at least, preserve your appeal rights.

BEWARE BAD ADVICE

On a related note, if you are communicating with the MAC, you cannot rely on the information the MAC provides. Federal courts have ruled that having followed bad advice from a government contractor does not protect against claims of wrongdoing. In other words, "but they told me to do it this way" is not an effective defense. You should therefore seek an attorney with experience in the appeals process, rather than going it alone.

INTERPRETING RULES, LAWS

You must understand that both ALJs and the DAB apply rigid analyses to legal interpretations. What may seem a "mere technicality" to you is often a perfectly valid basis for a revocation or denial of billing privileges, or a delayed effective date.

For example, in several recent appeals cases, ALJs have upheld delayed effective dates based on such "technicalities."

In one case, a physician practice initially submitted an

POWER POINTS

- Pursuing an appeal is a rigid and formal process. At each step, a physician must adhere to certain timeframes and requirements.
- The appeals process generally does not favor a physician appealing a decision.
- Administrative law judges and the Departmental Appeals Board usually presume matters in favor of the Medicare administrative contractor.
- Physicians should seek an attorney with experience in the appeals process.

"GOOD RESULTS CAN OCCUR WHEN A PHYSICIAN IS ASSISTED BY COMPETENT LEGAL COUNSEL."

out-of-date version of the CMS-855R reassignment form. The MAC promptly sent it back, instructing the physician to resubmit using the most current version of the form.

After the practice resubmitted the form, the MAC granted an effective date as of the date it received the second application. The practice challenged this determination, but the ALJ found in favor of the MAC.

In another case, an ambulatory surgical practice had its billing privileges revoked by the MAC because state law required a license to operate as an ambulatory surgical facility. The practice claimed that it had a permit from the state to perform ambulatory surgical services and therefore met the requirements. The ALJ, however, found in favor of the MAC, stating that the permit was insufficient because state law required a license to operate an ambulatory surgical facility.

Unfortunately, ALJs and the DAB lack the authority to be flexible in their interpretation of Medicare rules and laws.

FINDING IN FAVOR OF THE MAC

Another hurdle of the appeals process is the fact that ALJs and the DAB usually presume matters in favor of the MAC.

For example, a multispecialty clinic filed an appeal on a denial of billing privileges more than 60 days after the due date for the appeal. The clinic argued that it should not be time-barred from its appeal. However, the ALJ found for the MAC, explaining that, under federal regulations, ALJs and the DAB must presume that the recipient received the notice 5 days after the date on the notice, unless proven otherwise.

Similar presumptions apply when the question is whether (and when) a physician sent documentation to the MAC.

DEALING WITH DOCUMENTATION ISSUES

In one case, a physician practice sent its initial enrollment application to the MAC, which apparently lost the document. The practice sent a second application, which was fully processed, but the effective date of billing privileges was set as the date the MAC received the second application—not the first. The practice appealed, but the ALJ found in favor of the MAC, noting that the practice had not sent its documents using any method of delivery confirmation, and thus could not prove that the MAC had actually received the application.

In a different case, a submitting practice did use delivery confirmation, but the MAC claimed that pages were missing from the application. Again, the ALJ found in favor of the MAC, noting that delivery confirmation only proved that *something* was delivered, but not the *contents* of the delivery. The ALJ was unwilling to speculate that the MAC had intentionally ignored or hidden the missing pages, despite the practice's claims that the pages had been sent.

CONSIDER LEGAL COUNSEL

The landscape in the appeals process generally does not favor a physician appealing a decision. However, good results can occur when a physician is assisted by competent legal counsel. Going it alone—effectively "self-medicating"—runs the risk of missing or misstating key arguments and failing to meet filing deadlines, and it ultimately can cost a practice significant revenues—all of which may mean a loss of billing privileges altogether.

The appeals process is nuanced, formalized, and technical. Successfully navigating an appeal requires a solid understanding of the underlying enrollment process as well as the technicalities of the appeals process itself.

The author is a health law attorney with Alice G. Gosfield and Associates PC, Philadelphia, Pennsylvania. Law Consult deals with questions on common professional liability issues. Unfortunately, we cannot offer specific legal advice. If you have a general question or a topic you'd like to see covered here, please send it to medec@advanstar.com.