

# New Medicare Appeals Process Raises Concerns

*Advocate says that 'older people and people with disabilities will have problems' with teleconferences.*

BY JOYCE FRIEDEN

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A new process for appealing Medicare coverage denials is raising concern among some advocates for senior citizens.

"We're concerned about the ability of beneficiaries to get a fair and favorable hearing," said Vicki Gottlich, senior policy attorney at the Center for Medicare Advocacy, a Mansfield, Conn.-based group that helps beneficiaries with the appeals process. "Our organization and other organizations that do this kind of work have a very high success rate [for Medicare appeals] and we're concerned that the rate is going to go down."

That could mean collection snags for physicians, she added. For example, if the physician accepts assignment for Medicare, Medicare denies coverage for a claim, and the denial is unsuccessfully appealed by the patient, "the doctor will then have to go collect from the patient. They don't want to do that."

Under the new process, which began on July 1, beneficiaries and providers whose claims are denied will be asked to appeal their claims to an administrative law judge (ALJ) via teleconference. Previously, these appeals were made in person.

"Older people and people with disabili-

ties will have problems" with teleconferences, especially if their vision or hearing is impaired, Ms. Gottlich said. And if they ask for an in-person hearing instead, beneficiaries will waive their right to a timely decision if that request is granted. The new process also specifies that there will be three "regions" for hearing cases in person, rather than beneficiaries being allowed to have hearings in their home states.

Department of Health and Human Services spokesman Bill Hall said there are logistical reasons for waiving the right to speedy resolution in the case of an in-person hearing.

"We have to schedule everyone, allow time for them to travel, and set up a facility for the hearing," he said. "So logistics must come in play. That doesn't mean we'll take a year to do it."

Ms. Gottlich noted that the changes were made in the first place in part because members of Congress were dissatisfied with how long it was taking for beneficiaries to make their way through the appeals process.

"The changes are supposed to protect beneficiaries," but the system needs better funding to make sure everyone gets their chance to be heard in a timely way, she said. "There are some cases where teleconferencing could work, but for an

individual beneficiary who's gone through the whole inhuman system and wants to see a real person, the system doesn't really work."

Another change in the process places administrative law judges under the jurisdiction of HHS, rather than the Social Security Administration. Further, judges are instructed to place more weight on Medicare regulations than they were before. "The [law] says the administrative law judge is supposed to be independent of [the Centers for Medicare and Medicaid Services], but now they are supposed to give deference to their rules," Ms. Gottlich said.

Mr. Hall said that his agency "has gone to great lengths to be sure this is a fair process." Questions about how well the new system will work "are virtually impossible to answer because we haven't even heard the first case yet. I think it's a lot more fair to ask these questions a year from now."

The Medical Group Management Association, which represents medical practice managers, is one group that is very interested in how the appeals process plays out. "We have concerns about how effective arbitration or review will be through a distance," said Jennifer Miller, external relations liaison at MGMA's Washington office. "How effective can someone be to advocate their position over teleconference? When the rubber hits the road and we start seeing more [cases], we'll have a better feel for it."

Ms. Miller added that MGMA supports having the judges hired by HHS rather than the Social Security Administration. "Before now, someone dealing with disability issues would be trying to adjudicate what may be their third case of this type out of 300 cases, so they may not be as familiar with it," she said. "Now there will be a specialized group of magistrates—it's going to be a new breed of ALJ."

MGMA is not concerned that being hired by HHS will bias the judges too much, she added. "That is a concern many still share; however, ALJs historically have enjoyed a great deal of flexibility, and that's the genius behind the review process," Ms. Miller said.

Several senators expressed concern about changes to the appeals process. A bill, the Justice for Medicare Beneficiaries Act, sponsored by Sen. Christopher Dodd (D-Conn.), Sen. Edward M. Kennedy (D-Mass.), Sen. John Kerry (D-Mass.), and Sen. Jeff Bingaman (D-N.M.) was introduced earlier this summer and would reverse many of the changes.

For instance, the bill says that judges "shall not be required to give substantial deference to local coverage determination, local medical review policies, or Centers for Medicare and Medicaid Services program guidance." The measure also calls for appeal hearings to be in-person "unless such individual requests that the hearing be conducted using tele- or video conference technologies." The bill was referred to the Senate Finance Committee. ■

## Prepare Now for Launch of Medicare Part D Benefit in January

BY ELAINE ZABLOCKI

Contributing Writer

SAN DIEGO — Physicians will face many questions about the new Medicare Part D benefit in coming months as patients decide whether to enroll and which plan to select in the voluntary prescription drug program, Elizabeth Carder-Thompson said at the annual meeting of the American Health Lawyers Association.

The Centers for Medicare and Medicaid Services (CMS) has begun posting informational resources on its Web site, and additional materials will become available over the next few months. The best resource at this time is the "Outreach Toolkit," available by download or on CD-ROM, said Ms. Carder-Thompson, a lawyer with Reed Smith LLP.

"The Outreach Toolkit doesn't answer all the questions we want answered, but it's a good start," she said.

Enrollment for Part D begins on Nov. 15, 2005, and patients must enroll by May 15, 2006, or face a financial penalty when they do. The new coverage goes into effect Jan. 1, 2006, and the interim discount drug card program ends at that time. This means Medicare beneficiaries will need to make fairly complicated choices within a short time. There will be at least two Part D prescription drug plans available in each geographic area, and plans may include several subplans.

A Kaiser Family Foundation survey that was conducted in March and April of 2005 found that seniors are more likely to turn to their doctor (49%) or their pharmacist (33%) for help in making these types of decisions, rather than to Medicare information sources (23%). About two-thirds (68%) of those surveyed said they did not have a good understanding of the new benefit.

In October 2005, Part D plans will start to send out marketing materials. CMS will distribute its "Medicare and You," handbook to all beneficiaries via mail, with a description of the new benefit. A "Plan Comparison Web Tool" and "Medicare Personal Plan Finder" will be posted at [www.medicare.gov](http://www.medicare.gov), and there will be special mailings for low income beneficiaries.

"CMS says it will provide materials as they did for the drug discount card but this is far more complicated than the card," Ms. Carder-Thompson said.

According to Robert J. Hill, also of Reed Smith LLP, the CMS marketing guidelines on Part D include a great deal of material that will affect physicians. For example, enrollment cannot be taken at the point of care, such as a physician's office. If physicians offer their patients information on any Part D plan then they must offer information on all available Part D plans.

CMS has not released the final version

of its marketing guidelines, and Mr. Hill expects these issues to be dealt with in more detail in the second part.

Once Part D becomes effective, doctors will face a different set of concerns, Ms. Carder-Thompson said.

When a plan doesn't cover a prescribed drug, physicians will need to provide supporting statements in order to get an exception, but many details are not clear at this time.

"The regulation is confusing," Ms. Carder-Thompson said.

"CMS says they don't want it to be hard to seek exceptions. However, it may well become an administrative burden. This is something that's going to evolve as we go along," she commented.

Ms. Carder-Thompson advised physicians to "stay tuned" on the details of Part D, because they seem to be changing every day. ■

