

Take Five Steps to Appeal Medicare Part B Denials

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LAS VEGAS — On Jan. 1, Medicare officials implemented a new five-step process for appealing Medicare Part B claims.

The changes apply to Part B initial claim determinations issued and mailed on or after that date, Edward R. Gaines III, senior vice president for compliance and general counsel at Healthcare Business Resources Inc. of Durham, N.C., said at a meeting on

reimbursement sponsored by the American College of Emergency Physicians.

The new process includes some significant procedural differences that could benefit physicians, including an opportunity for an independent review earlier in the process, Mr. Gaines said in an interview. The new process includes these steps:

► **Step 1.** The process begins with a "redetermination" of the initial claim decision made by the Part B carrier. The redetermination is also made by the Part B carrier but

the appeals decision is made by an employee who was not involved in the initial determination. This is the only step in the process that involves the Part B carrier that made the original decision, Mr. Gaines said.

Physicians have 120 days from the receipt of the notice of initial determination to file an appeal. Mr. Gaines recommended filing all documentation with the letter requesting a redetermination, including case summaries explaining your code selection. Otherwise, the carrier automati-

cally receives up to 14 additional days to its 60-day decision deadline.

► **Step 2.** Providers can appeal the redetermination decision in a step called reconsideration. Physicians have 180 days from the date of receipt of the redetermination to file this appeal with the Qualified Independent Contractor (QIC) indicated in the Part B carrier letter.

The redetermination step replaces the old "fair hearing" process. The old process was frequently criticized since the fair hearing officer usually had close ties to the Part B carrier that made the original decision, Mr. Gaines said.

He recommended submitting all relevant evidence in support of the claim when the notice of reconsideration is submitted because this is a new review and the QIC will not consider what the carrier ruled previously.

QICs are bound by Medicare national coverage decisions, CMS rulings, laws, and federal regulations. But they are not bound

by other documents including local coverage decisions, program guidance, or manual instructions, he said. The reconsideration decision is rendered within 60 days under the appeals process.

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► **Step 3.** A hearing with an administrative

law judge is held in person, by video, or by telephone. Otherwise, the administrative law judge (ALJ) will base his or her decision on the written record. To have an ALJ review the appeal, submit a written request within 60 days of the reconsideration notice. At this level of the appeal, at least \$110 must be in dispute.

In order to get an in-person hearing, physicians must make that request before the hearing date is set and explain why a telephone or video hearing is not acceptable, Mr. Gaines said. Consider obtaining legal counsel at this point in the process, Mr. Gaines advised.

► **Step 4.** If still not satisfied, a provider may appeal to the Medicare Appeals Council. This must be done within 60 days from the receipt of the ALJ decision. The Medicare Appeals Council is another addition to the process. Previously, physicians who wanted to appeal a decision beyond the ALJ would have to go to federal district court, and few physicians took that step, Mr. Gaines said.

There is no right to a hearing before the council but physicians can request an oral argument. In addition, parties to the appeal can file briefs.

► **Step 5.** The final appeal is to the federal district court. This must be filed within 60 days of the Medicare Appeals Council decision. The case may be filed in the U.S. District Court where the appealing physician resides. At this step in the process, at least \$1,090 must still be in dispute. ■

Excessive Sleepiness

Hypersomnolence: A Multidimensional Impact on Life

By definition, hypersomnolence (excessive sleepiness, or ES) consists of unintended periods of drowsiness or sleepiness that occur during desired waking periods.¹ ES is associated with narcolepsy, obstructive sleep apnea (OSA), and shift work sleep disorder (SWSD), and it can also be caused by multiple sclerosis, Parkinson's disease, mood disorders, and many other neurological and psychological disorders.¹ Regardless of the cause, ES can impact life in ways that merit further consideration.

Job performance reexamined

True ES symptoms should be differentiated from fatigue, tiredness, and lack of motivation, all of which may be perceived by employers as laziness.² Patients with untreated OSA, narcolepsy, or other disorders with ES are more likely to be involved in work-related accidents than the general public, and to incur higher healthcare-related costs.³

Driving while impaired

The effects of ES do not end with the workday. ES can adversely affect concentration, so it is not surprising that the risk of auto accidents is higher in people who experience ES, such as shift workers and people with undiagnosed sleep disorders.⁴ The drive home after a full workday can be the most hazardous part of the day for a patient with ES.

Family and social consequences

ES can impair a patient's spousal or family relationships, too. The consequences of chronic ES may include mild to severe fatigue, crankiness, and home accidents.⁵ Poor motor, mental, and cognitive function at home can significantly impact a patient's quality of life.⁶

ES and cognitive performance

Patients may experience symptoms of "executive dysfunction" accompanying excessive sleepiness, including impaired verbal fluency, serial learning deficits, problems focusing attention, and concentration difficulties.³ Similarly, degree of sleepiness has been correlated with results of psychomotor vigilance task (PVT) studies.⁷ Other PVT research confirms that sleep loss and alcohol consumption have a comparable negative effect on psychomotor performance.⁸

Lapses in cognitive efficiency as a result of ES can also be evaluated using the Cognitive Drug Research (CDR) System, which was developed to assess both enhancement and impairment of human cognitive performance in a clinical trial setting.^{9,10} In one such use, the CDR System indicated that attention and memory suffered as a result of working long hours in a surgical unit without sleep.¹¹

Wakefulness when wakefulness matters

Importantly, ES is often symptomatic of an underlying condition that merits attention, rather than the result of deficiencies in the quality or quantity of an individual's sleep. Therefore, identification and treatment of the underlying condition are critical priorities. Once the underlying condition has been managed, the clinician may choose to continue to evaluate the effects of ES with the Epworth Sleepiness Scale (ESS), which measures the likelihood of dozing during 8 commonly encountered daytime situations.¹² Once the impact of excessive sleepiness is understood, the clinician can begin to focus on managing ES by extending wakefulness throughout the day.

For more information about managing ES in your clinical practice, please visit www.ExcessiveSleepiness.com.

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