Appealing Medicare Denials

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Because of the government’s recent emphasis on controlling health care costs, health care providers have been receiving many more denials for payment of services rendered to Medicare beneficiaries than in the past. Often the denials are not justified and should be appealed. This article explains the step-by-step procedure in the Medicare appeals process and gives suggestions for presenting a case so that a denial will have a good chance of being overturned.

History of the Medicare Program

Legislation was signed into law in 1965 to create the Medicare program. Title XVIII of the Social Security Act created Medicare as a federal insurance program to meet the health care needs of older Americans. Since the late 1960s, Medicare has evolved to cover many more people and services. The program has had a significant effect on the delivery of health care services in America and also is frequently blamed as a major factor in skyrocketing health care costs. The government has been attempting to control these costs through such actions as the prospective payment system and closer review of claims submitted for reimbursement.

The Health Care Financing Administration (HCFA) has contracted with various private insurance companies, called intermediaries, to carry out the Medicare program in different parts of the country. A provider will usually submit claims or bills for reimbursement of services to one intermediary in his or her region. This intermediary then reviews the claims and either pays or denies reimbursement after determining if the claims meet Medicare guidelines.

Initially, to give health care providers an incentive to participate in the Medicare system even if some of their claims should be retroactively denied, the government established the Medicare waiver of liability provision. (The waiver of liability provision was repealed in March 1986 but reinstated a few months later because of complaints by providers.) This provision gives relief to providers who act in good faith in providing Medicare beneficiaries with services that an intermediary may later find to be unreasonable or unnecessary and for which, therefore, it retroactively denies reimbursement. Providers maintain a favorable presumption or waiver of liability as long as the percentage of their claims retroactively denied does not exceed 5% in any one quarter of the year. The provider will be paid for all claims (including denied claims) if he or she has a favorable presumption for reimbursement.
that quarter. Once the 5% denial rate is exceeded for any one quarter, the provider will not be paid for any claims denied in that quarter.

Some health care professionals and advocates believe that government policies to contain costs, which have caused HCFA to put pressure on intermediaries to deny claims, have compromised the incentive to participate in the Medicare program. Often these denials are erroneous and have resulted in limiting Medicare beneficiaries’ access to medical care (Deane, 1986; Hulin & Hulin, 1986). Occupational therapists, in particular, are in danger of having their claims for reimbursement denied because many claims reviewers have a limited knowledge of occupational therapy.

However, in an article on appealing denials, Baer (1986) advocated appeal because the odds are with the provider. Baer reported that according to statistics, 34% of all denied claims are reversed at the reconsideration stage and 90% at the hearing stage. Furthermore, Charles Hulin and Judith Stein Hulin, founders of an organization to provide legal assistance to Medicare patients (LAMP), reported that denials were overturned in 70% to 80% of cases they appealed (Hulin & Hulin, 1986).

Medicare Coverage of Occupational Therapy Services

When providing occupational therapy services to Medicare beneficiaries, it is important to have a good working knowledge of the Medicare coverage guidelines. This will help both to document services for reimbursement properly as well as increase the chances of an appeal’s being successful if a claim is denied.

The Health Insurance Manuals (HIMs) contain administrative interpretations of the Medicare regulations and coverage criteria. The Occupational Therapy Medicare Handbook (AOTA, 1987) has a summary of this information. This handbook reviews the specific coverage criteria unique to various settings (i.e., home health, skilled nursing facilities, outpatient clinics, etc.). It also contains the Medicare coverage guidelines for occupational therapy, which pertain to all settings. These guidelines are summarized in the handbook (AOTA, 1987) as follows:

A. General—Occupational therapy is a medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, improving the individual’s ability to perform those tasks required for independent functioning. Such therapy may involve:

1. The evaluation or reevaluation as required of a patient’s level of function by administering diagnostic and prognostic tests;

2. The selection and teaching of task-oriented therapeutic activities designed to restore physical function;

3. The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall “active treatment” program for a patient with a diagnosed psychiatric illness;

4. The planning and implementing of therapeutic tasks and activities to restore sensory integrative function;

5. The teaching of compensatory techniques to improve the level of independence in activities of daily living;

6. The designing, fabricating, and fitting of orthotic and self-help devices

7. Vocational and pre-vocational assessment and training.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate . . . a patient’s level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient’s level of function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist.

B. Coverage Criteria—To constitute covered occupational therapy for Medicare purposes, the services furnished to a beneficiary must be (a) prescribed by a physician, (b) performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist, and (c) reasonable and necessary for treatment of the individual’s illness or injury. (pp. C-3–C-4).

The first two coverage criteria are objective and not subject to interpretation. The third coverage criterion is more subjective and is explained further in the guidelines:

Occupational therapy treatment designed to improve function is considered reasonable and necessary for the treatment of the individual’s illness or injury only where the expectation exists that the therapy will result in a significant practical improvement in the individual’s level of functioning within a reasonable period of time. Where an individual’s improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would be excluded from coverage.

Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services are covered even though the expectation may not be realized. However, the services would be covered only up until the time it would have been reasonable to conclude that the patient is not going to improve. . . . Generally speaking, occupational therapy is not required to reflect improvement or restoration of function where a patient suffers a temporary loss or reduction of function (e.g., the temporary weakness which may follow prolonged bedrest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. (p. C-4)

Documentation of Occupational Therapy Services

Documentation is extremely important in demonstrating that the specific coverage criteria have been met,
that the services were reasonable and necessary, and that the services were covered services according to the Medicare guidelines. Keeping the Medicare coverage guidelines in mind, therapists should include the following information in their documentations. The initial evaluation should include

1. The date of the evaluation
2. The primary diagnosis and date of onset of the problem
3. Any concomitant diagnoses or medical history that may affect the patient's functional status or participation in the therapy program
4. The patient's prior functional status
5. The patient's support system
6. The patient's level of motivation and goals
7. The patient's present status and functional limitations
8. A treatment plan that addresses problems identified in the initial evaluation and establishes measurable functional goals related to these problems (for example, an identified problem might be that the patient is unable to perform lower extremity dressing tasks. The measurable goal might be that the patient will be independent in lower extremity dressing using adaptive equipment as needed)
9. Time frames to meet goals

This documentation will establish that illness or injury has impaired an individual's ability to perform those tasks necessary for independent functioning and that the treatment is designed to improve or restore those functions within a reasonable period of time. In addition, the documentation should establish that there is an expectation that the patient's level of function will improve if he or she receives occupational therapy treatment.

The progress notes should record the following:
1. The skilled service that has been provided to the patient
2. The progress the patient has made to date in measurable terms
3. Short-term goals, including any goal modification or change in time frame and the reason for this change

The documentation needs to establish that the service provided is a covered service under the Medicare guidelines. The progress notes should also indicate whether the patient is making functional improvements as expected, and if not, what changes in the program or time frame this lack of improvement necessitated.

Good documentation is essential to justify the services provided. In the event the intermediary denies payment for services provided, documentation will be extremely important in appealing the denial.

**The Medicare Appeal Process**

Essentially, the procedure for review of a claim begins with the intermediary's initial determination of the validity of the claim. Usually the intermediary will either pay the claim or, if it has a particular question about the necessity of a particular service provided, will ask for and review the appropriate medical records before making a decision. If the intermediary decides the service is not covered, it will send the beneficiary and the provider an initial determination of denial. This initial determination will state the reason for the denial and state who is liable for the uncovered services, or, in other words, who suffers the financial loss. If a beneficiary is not held liable for the services, it is usually because the intermediary has determined that the beneficiary had no way of knowing the services were not covered. It is important to note that the denial notice informs the beneficiary that receipt of the notice constitutes evidence that the beneficiary was made aware such services were uncovered, and that he or she will not be protected from liability in the future for such services if it is determined that these services involve treatment for a similar condition. If the intermediary declares that the beneficiary is liable, the beneficiary may have to pay for the services. If the provider is covered under the waiver of liability provision, the intermediary may still pay the claim. If the provider is not covered under the waiver of liability provision, the beneficiary may have to take the financial loss.

If a beneficiary or provider is dissatisfied with the initial determination, he or she has certain appeal rights. The beneficiary may appeal the denial even if he or she has not been held liable. The provider may initiate an appeal only if the ultimate liability rests with the provider (i.e., if the services were not covered under the waiver of liability provision) or with the beneficiary but the beneficiary will not exercise his appeal rights, as evidenced by the fact that either (a) the beneficiary's liability was entirely waived in the initial determination or (b) the beneficiary or his or her representative has stated in writing that he or she does not intend to request a reconsideration.

There are four steps to the appeals process (Social Security Act of 1965). Given below is the action to be taken at each step, the minimum dollar value of the claim that can be appealed at each step, and the time frame within which each step must be taken.

**Step 1: Reconsideration by intermediary.** Request must be made to intermediary within 60 days of receipt of initial determination; no dollar minimum.
Step 2. Hearing before an administrative law judge. Request must be made to intermediary or Office of Hearings and Appeals within 60 days of receipt of reconsideration determination; $500 minimum.

Step 3. Review by Appeals Council. Request must be made to Appeals Council within 60 days of receipt of hearing decision; $500 minimum.

Step 4. Review by U.S. district court. File request with U.S. district court within 60 days of Appeals Council decision; $1,000 minimum. (This step is not applicable to Part B claims.)

Step 1

The appeal for reconsideration must be made within 60 days of receipt of the initial determination and can be done by writing to the intermediary, requesting reconsideration. Upon receipt of the request for reconsideration, the intermediary will again request the relevant medical records and allow submission of any additional information pertinent to the review. This may include any supplementary information, such as a more detailed discussion of the patient’s diagnosis and limitations, a fuller description of the services provided and a fuller explanation of the necessity for these services and their benefit to the patient, attendance records, research articles on the effectiveness of the treatment chosen, etc.

Once the intermediary receives this information, it will have a specially trained staff, different from the staff that made the original decision review the case. In the reconsideration determination, the intermediary will summarize the medical records, declare whether or not it found the original determination to be correct, and then state the reason the original determination is being either upheld or overturned.

Step 2

If the reconsideration determination upholds the original determination, the party making the appeal has 60 days from the receipt of this second determination to request a hearing before an administrative law judge. Such a request may be made only if the amount in controversy is over $500. The request for a hearing must be made by writing to the intermediary or to the central office or any local office of the Social Security Administration’s Office of Hearings and Appeals. The hearing is usually held in a local office of the Office of Hearings and Appeals.

As previously noted, the odds are with the beneficiary or provider who appeals, particularly at the hearing stage. The administrative law judge is not under HCFA, where there is pressure to deny claims, and will usually be more sympathetic to individual patient cases. At the hearing, those appealing the denial present their case to the administrative law judge. The intermediary is not physically represented at the hearing; however, its representative will have sent to the judge the file containing all the information on the case, such as the initial determination, the reconsideration determination, and the medical record documentation. Those who are appealing the case may have legal representation; however, this is not mandatory or necessary. If the provider is appealing the case, the beneficiary need not be present if he or she has no financial interest in the case.

The costs incurred in appealing a case may include (a) fees for legal counsel, if used; (b) cost involved in preparing the case, such as salaries of the personnel involved in gathering, compiling, and typing reports pertinent to the case; and (c) salaries of any health professionals testifying at the hearing.

Hearings last approximately 1 to 2 hours. No fee is required to request a hearing. Because no specific legal expertise is required, any occupational therapist would be able to prepare and present the case, thereby saving the cost of legal counsel.

The hearing is usually informal. The administrative law judge may ask the party appealing the case to present the case, or the judge may ask specific questions to establish the facts of the case. After the case is presented, the judge will consider all the information in the case and issue a decision in writing—usually within 90 days.

Step 3

After the administrative law judge renders his decision, either party—the intermediary, or the provider or beneficiary (depending on who appealed the case)—has the right to ask the Appeals Council at the HCFA office in Baltimore to review the case. This request must be made by writing to the Appeals Council within 60 days of receipt of the hearing decision. The Appeals Council also has the right to review the case on its own motion if there appears to be an abuse of discretion by the administrative law judge, an error of law, or if conclusions were drawn that are not supported by substantial evidence. The Appeals Council also has the right to refuse to review the case, even if requested to review it.

Step 4

Finally, if the provider or beneficiary is dissatisfied with the decision of the Appeals Council, or if the Appeals Council refuses to review the case and the amount in question is over $500, the decision may be appealed to the federal district court. This would be done by filing the appeal with the federal district court in which the beneficiary resides or the provider has a place of business. The appeal must be filed
within 60 days of receipt of the Appeals Council decision.

Example of a Case Appealed to Hearing

The following is a summary of the history of a case successfully appealed at the hearing level ("Medicare Denial," 1986):

The intermediary denied reimbursement for occupational therapy services provided to an 81-year-old woman who had suffered a fracture of the left hip and had a total hip replacement. The initial determination, which was sent to the beneficiary and the provider, stated that the treatment was not consistent with the symptoms and/or diagnosis and could have been provided by physical therapy or nursing personnel. The intermediary determined that the beneficiary was not liable for the services provided because there was no way for her to know the services were uncovered. The intermediary also contended that the provider should have known the services were uncovered because the Medicare coverage guidelines for occupational therapy services are outlined in the HIM. Therefore, the provider was not even eligible to be paid for the services under the waiver of liability provision.

Upon written request for reconsideration, the intermediary upheld the original denial, concluding that there was no documentation in the medical records to indicate that the patient required the services of an occupational therapist. The facility where the services were provided contended that the services were covered under the Medicare guidelines and that the intermediary had denied payment for the service based on misinterpretation of these guidelines. Therefore, a hearing before an administrative law judge was requested. When the case was heard, several facts demonstrating compliance with the Medicare guidelines were established.

Documentation to Support Objective Coverage Criteria

To show that the objective coverage criteria had been met, the following were presented: (a) copies of the medical records showing that occupational therapy had been ordered by a physician and that he approved the plan of treatment, and (b) copies of all occupational therapy documentation indicating that the services were provided by a qualified occupational therapist.

Documentation to Support "Reasonable and Necessary Services" Criterion

To demonstrate that the coverage criterion requiring that the services be reasonable and necessary had been met, the following documents were produced. First, a copy of the occupational therapy initial evaluation and a summary of the functional limitations experienced by the patient were presented.

In the summary of findings from the initial evaluation, it was emphasized that the patient was an elderly woman who, prior to surgery for total hip replacement, had lived alone in an apartment and had no support system in the community. Her nearest relative lived over 1,000 miles away. This patient had other secondary diagnoses as well as the general complications due to the aging process such as decreased balance, vision, and sensation, generalized weakness, and brittle bones. Like many elderly people, she had lived on the margin of independence until the trauma of a fractured hip as well as surgery for a total hip replacement had pushed her over the edge. Therefore, it could not be expected that normal activities would be resumed spontaneously. The evaluation findings revealed that the patient now required assistance with lower extremity bathing and dressing; was unable to transfer herself to and from bed, the toilet, or the bathtub; was unaware of the necessity of observing total hip precautions; lacked knowledge of the safety and energy conservation techniques needed to perform functional activities after surgery for a total hip replacement; and was now dependent in homemaking activities. It was stressed that the occupational therapist's initial evaluation had demonstrated that the patient's condition had impaired her ability to perform those tasks required for independent functioning and that in view of her intact mental status, prior functional status, and strong motivation to return home, there was a strong expectation that occupational therapy services would result in a practical level of improvement in her level of functioning within a reasonable period of time.

Second, a copy of the treatment plan and a more detailed explanation of the skilled services provided to the patient were presented. It was emphasized that the skilled services provided focused on the teaching of compensatory techniques to improve the level of independence in activities of daily living and were therefore covered services under the Medicare guidelines. These services included educating the patient in the use of adaptive equipment to perform lower extremity bathing and dressing, educating the patient in compensatory techniques and in the use of the adaptive and safety equipment needed to maintain total hip precautions while performing such functional activities as getting in and out of bed and transferring to and from a toilet or bathtub, and educating the patient in energy conservation and safety techniques in the performance of homemaking activities.

Third, a copy of the occupational therapy discharge summary was presented. This summary docu-
mented that as a result of occupational therapy intervention, the patient had improved from the status of requiring assistance to that of being independent in the performance of all tasks required for her to return home to live independently.

Fourth, testimony was given by the directors of Occupational Therapy, Physical Therapy, and Nursing to dispute the intermediary's statement in the initial determination that physical therapy or nursing personnel could have provided the services. The directors reviewed the educational background and roles of their respective professions and emphasized that the occupational therapy treatment rendered to this patient could have been provided only by a qualified occupational therapist. It was also emphasized that the Medicare guidelines specifically state that

only a qualified occupational therapist has the knowledge, training, and experience required to evaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. (AOTA, 1987, pp. C-3-C-4)

The intermediary was not represented at the hearing, having already forwarded its file on the case to the administrative law judge. Information contained in the file included the initial determination, the reconsideration determination, and copies of the medical records.

In a decision rendered 2 months after the hearing, the administrative law judge overturned the denial. The written decision stated that occupational therapy was indeed medically necessary for this patient as well as for all patients with hip replacements and hip fractures. The judge found that if these patients 'are not professionally attended to through appropriate occupational therapy during the recuperatory period, significant adverse events are likely to occur' ("Medicare Denial," p. 1). The judge also stated that "the overall situation of the elderly patient makes the need to provide effective occupational therapy even more compelling and dramatic" ("Medicare Denial," p. 1). The judge ruled that the occupational therapy services were essential in enabling this patient to return home to live independently. Also reinforced in the decision was the fact that testimony indicated that physical therapists and nurses were not trained to provide these services and that under unambiguous provisions of the Medicare guidelines, the services would not be covered if provided by anyone other than an occupational therapist or qualified assistant. The intermediary was admonished for arbitrarily denying reimbursement for these services after having established facts similar to those elicited at the hearing, yet drawing a totally contrary conclusion.

Summary
Government policies to control rising health care costs have caused an alarming increase in arbitrary denials for payment of services rendered to Medicare beneficiaries. As a result, access to health care for some Medicare beneficiaries is being limited. Occupational therapists who are thoroughly knowledgeable about the Medicare coverage guidelines and appeals process and who use this knowledge in preparing their cases have an excellent chance of overturning such denials.

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References