

New Medicare Appeals Process Raises Concerns

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

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 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 disabilities 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 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."

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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 Sens. Christopher Dodd (D-Conn.), Edward M. Kennedy (D-Mass.), John Kerry (D-Mass.), and 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 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. ■

Physician Part D Education Efforts: An 'Unfunded' Mandate?

BY NELLIE BRISTOL

Contributing Writer

WASHINGTON — Physician obligation to help patients negotiate the upcoming Medicare Part D outpatient drug benefit will result in "another unfunded mandate" for Medicare providers, Ronald Castellanos, M.D., chairman of the Practicing Physicians Advisory Council said at the group's recent meeting.

Noting that patients are most likely to rely on their physicians for aid in choosing among the new drug plans, Dr. Castellanos said, "Basically what you're doing is putting the burden on physicians in their offices to really educate the Medicare recipient."

PPAC members asked the Centers for Medicare and Medicaid Services to make educational materials as simple possible, including information on whether beneficiaries are eligible for the low-income portion of the program.

"I really want a lot of information, very digestible," said PPAC member Geraldine O'Shea, D.O., an internist from Jackson, Calif. "Something very easy for them to understand, because I do not want to take time out of my time to do medicine with my patient to say, 'Well, let me see your tax return.'"

"We are trying to make the information available as simple as possible," said Jeffrey Kelman, M.D., medical officer for the CMS Center for Beneficiary Choices, noting that he would bring educational material to the council's next meeting.

Council member Barbara McAneny, M.D., an oncologist from Albuquerque, requested the agency to develop a computer program that would allow physicians to type in the drugs a patient is using and come up with a plan to cover all of them.

She also proposed a draft recommendation that would require CMS to develop a reimbursement code for physician time spent on drug plan education, but it was voted down by the panel, with members saying it wasn't practical.

Walking through the benefit, Dr. Kelman said CMS is getting "much more ro-

bust formularies" from drug plans than officials had anticipated. "They're looking like commercial formularies," he said. He added that the formularies would be available on the Web site in October.

All drugs approved by the Food and Drug Administration must be on the formularies, Dr. Kelman said. If a drug is not included, a beneficiary can appeal, based on medical necessity, but "preferably with a physician's help," he said. "All medically necessary drugs that are approved by the FDA with certain exceptions... have to be available." However, off-label prescriptions will be covered, Dr. Kelman said.

In a move important to rare-drug organizations, Dr. Kelman said if there is only one drug to treat a disease, it must be included in the formulary.

Part D also will ensure drugs are available for chronic conditions by "favorably risk adjusting" those diseases, Dr. Kelman said. The plans also will "overadjust" for low-income individuals and nursing homes.

"We went to a lot of trouble to ensure nobody was discriminated against on the formulary or based on the Part D benefit," Dr. Kelman said. He said formularies would be compared to others in their region and to commercial plans.

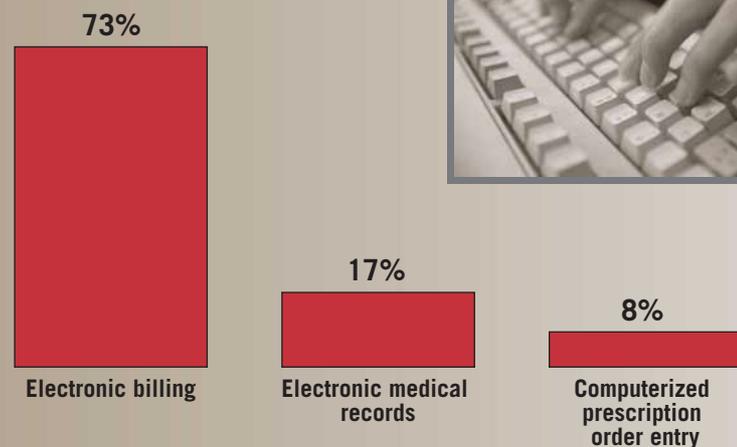
Council member Laura Powers, M.D., a neurologist from Knoxville, Tenn., said she was relieved by Dr. Kelman's comments. "We were so worried that our patients with very expensive drugs were going to be eliminated from all the formularies."

Dr. Kelman urged physicians to begin moving patients to the new formularies before the benefit is effective Jan. 1, 2006. "The last thing we want is 40 million exceptions and appeals in the first week," he said. Beneficiaries can enroll in the program from Nov. 15 through May 15.

Dr. Kelman also noted that by law, barbiturates and benzodiazepines will not be covered. Those medications are inexpensive and the program was hoping states would continue to pay for them for beneficiaries receiving both Medicaid and Medicare benefits. Cosmetic agents and weight-management products also will not be covered. ■

DATA WATCH

Information Technology Used Mostly For Electronic Billing in 2003



Note: Based on estimated data from the National Ambulatory Medical Care Survey of about 1,114 office-based physicians.

Source: Centers for Disease Control and Prevention