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Part B Insider (Multispecialty) Coding Alert

Appeals: CMS Requires Independent Carrier Hearing Officers

Changes help level playing field

A formerly insignificant legal argument may soon become the centerpiece of your appeals of claims denials, thanks to yet another change in CMS' appeals policies.

As of this year, carriers can no longer collect overpayments until they prevail in the appeals process (see PBI, Vol. 5, No. 8).

Starting in October, the first level of appeals will be called "redeterminations," and the carriers will be sending you redetermination notices informing you of their decisions. Learning how to read these documents will be vital to your survival.

According to the **Centers for Medicare & Medicaid Services**, these documents will include a summary of your case, plus a section titled "what to include in your request for independent appeal."

In their decisions, the carriers will have to identify specifically which local coverage decision they used to make a determination, notes attorney **Alan Reider** with **Arent Fox** in Washington. If the letter fails to list a particular LCD (or LMRP), the physician can use the "waiver of liability" defense, which says, "there's no reason why I should have known you would deny this due to medical necessity," Reider explains. Carriers can't just invent policies on the fly -- they have to publish them and then apply them.

In the past, the waiver of liability defense often hasn't been used successfully, but that could change with these new notices, says Reider. But once you use that argument for a particular policy, you can never use it again, because after that, the carrier's policy is public knowledge.

In the past, the second level of appeals went to hearing officers who were carrier employees, but now the appeals will go to qualified independent contractors. Neither the Administrative Law Judges nor the QICs are bound by carriers' LCDs, notes Reider.

The sooner you prepare for the October 1 implementation of these new policies, the better. "Any change is going to cause a delay for the average practice only because they're going to have to change the way they process their information," notes consultant **John McDaniel** with **Physician Management Group** in New Orleans. "Very few of these changes result in improved reimbursement."

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