Medicare's Appeals Process

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The ALJ hearing must be requested within 60 days of the date on which the hearing officer's decision was received. The request must be submitted in writing to the carrier or the hearing officer who rendered the decision. When the ALJ hearing is requested, all relevant documentation should be submitted to the ALJ office where the hearing will be scheduled, and all parties should be notified. The ALJ hearing is considered a new proceeding based solely on what is submitted with the case file. In many instances, the carrier (HCFA's agent) elects not to send anyone to these hearings, as the financial constraints of sending staff to all ALJ hearings can become onerous. These hearings give appellants a good forum, free of carrier input, to argue their cases and provide additional support for their claims.

Because ALJs deal primarily with Social Security Administration cases (approximately 95 percent of their caseload), they require education on the claim and the procedure's necessity and efficacy as well as the logic behind the physician's decision to provide a certain service or procedure. The biggest drawback to pursuing an ALJ hearing is the length of time it requires. ALJs average nearly two years (664 days) to render their decisions. Also, even after a decision is made, ALJ cases set no precedents.

Step 4—Appeals Council

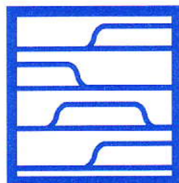
Physicians may request a review of an ALJ's decision by the Appeals Council of the Social Security Administration's Office of Hearings and Appeals within 60 days. This request for review is termed a "protest" and specifically challenges the ALJ's interpretation of the law.

If the Appeals Council decides to reopen the case, it will review the ALJ's decision and any additional documentation submitted by the appellant. If the physician fails to exercise this appeal right within 60 days, then he or she loses the right to appeal in federal court.

If the council refuses a physician's "protest" out of hand, then an appeal to the Federal District Court can be filed based simply on the refusal. The council has 120 days to make a determination.

Step 5—Federal District Court

The last resort for physicians is taking civil action in the judicial district within 60 days of the council's notice. In this case, the HHS is named as the defendant, and a summons of the complaint is submitted to the HHS general counsel. If a physician (now the plaintiff) appeals as far as federal district court, then the case could set a legal precedent. ❑



CODING AND REIMBURSEMENT UPDATE

Diagnosis Coding for Echocardiography

Selecting an appropriate ICD-9 code to report echocardiography has proved to be a coding conundrum for many billing personnel. Many Medicare carriers have developed reimbursement policies that severely limit the ICD-9 codes they will accept as medically necessary to perform an echocardiogram. These policies are difficult to obtain from various carriers. It is suspected that the Medicare carriers are concerned that, once reviewed, the provider will orient the reported diagnosis to ensure that the services will be covered.

The problem of reporting an appropriate diagnosis is exacerbated when the patient has been referred to the cardiologist for a preoperative clearance or when the cardiologist is under contract to interpret echocardiograms for institutions. According to the Health Care Financing Administration (HCFA), the diagnosis of the physician performing the diagnostic examination (or the receiving physician) must be consistent with the diagnosis of the requesting physician. This requirement is to facilitate correct reporting of the reason the procedure was performed. HCFA also reminds providers that when they perform a diagnostic procedure, they must report why the test is being done and not what the test confirmed.

To avoid potential denial of the echocardiogram, it is recommended that the cardiologist who performs the echocardiogram on a consultative basis urge referring physicians to provide specific diagnoses (i.e., symptoms and signs) and not "rule-out" reasons for the test. HCFA will deny diagnostic tests if they are reported as "rule-out" or screening tests. If referring physicians continue to provide "rule-out" diagnoses and/or vague reasons for their requests for an echocardiogram, then it may be helpful for cardiologists to communicate to their usual referring physicians specific cardiovascular symptoms that may be valid reasons to perform an echocardiogram.

Reporting preoperative clearance procedures is another area of concern. Although many carriers will deny the use of V codes 472.81, 72.82, 72.83, and 72.84 as the primary diagnosis codes followed by a secondary code indicating why the surgery is being performed, most professional coders agree that, in a preoperative clearance situation, this format is considered correct coding. For example, when a cardiologist is asked to provide preoperative clearance for a cholecystectomy, the report should specify ICD-9 code V72.81 as justification for performing the service. This code should be followed on the billing form by the diagnosis code, which has been provided by the referring surgeon (e.g., the reason the surgery is being performed). HCFA admits that denial by carriers of V codes as a primary diagnosis is inappropriate. It recommends that physicians appeal these denials by communicating with the medical director of his or her carrier and explaining the rationale of reporting the service with the V code.

If the cardiologist is aware that the diagnosis he or she is given as the reason for performing an echocardiogram will be denied by Medicare, then he or she should make sure the patient has signed a waiver explaining that Medicare will not pay for an echocardiogram for this specific diagnosis and that the patient will be responsible for the charges associated with the test. The modifier "–GA" should be used on the claim form to ensure that the patient will not receive an explanation of benefits that releases his or her responsibility for paying the bill and disables the cardiology practice from billing the patient. ❑