Latest Policy & Regulatory Changes to the Medicare Appeals Process

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Judge Nancy Griswold
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Medicare Appeals Backlog

- "Despite significant gains in OMHA ALJ productivity…, and CMS and OMHA initiatives to address the increasing number of appeals, the number of requests for an ALJ hearing…continue to exceed OMHA's capacity to adjudicate requests." 82 Fed. Reg. 4974, 4976 (Jan. 17, 2017)
- As of September 30, 2016, OMHA had over 650,000 pending appeals. 82 Fed. Reg. 4974, 4976 (Jan. 17, 2017)
- What has been done and what needs to be done to rectify the backlog?
- How will these activities impact providers' and suppliers' audit and appeal strategies?

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Judicial Relief: Medicare Appeals Backlog

Hospice Savannah, Inc. v. Burwell (4:15-cv-00253-JRH-GRS) (Sept. 21, 2015)

- District court awarded Hospice Savannah a temporary restraining order (TRO) enjoining HHS from withholding, recouping, offsetting, or otherwise failing to pay any current Medicare receivables
  - Substantial likelihood of success on the merits based on a "questionable extrapolation"
  - Hospice Savannah will be irreparably harmed by being forced to close and being unable to provide ongoing care to current hospice patients who by definition are terminally ill and disabled
  - Little or no risk to HHS because, at worst, the TRO will only defer its ability to pursue collection efforts
  - Public has an interest in seeing that terminally-ill patients continue to have access to Hospice Savannah's services

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Judicial Relief re: Appeals Backlog

American Hospital Association, et. al. v. Burwell (No. 1:14-cv-00851) (Feb. 9, 2016)

- AHA sought a writ of mandamus compelling HHS to act within the specified appeal time frames
  - "[ALJs] shall conduct and conclude a hearing . . . and render a decision . . . by not later than the 90-day period beginning on the date a request for hearing has been timely filed." 42 U.S.C. § 1395ff(d)(1)(A)
- District court concluded mandamus relief was unwarranted
- Reversed and remanded by United States Court of Appeals for the District of Columbia Circuit
  - "[C]ommon sense suggests that lengthy payment delays will affect hospitals' willingness and ability to provide care."
  - Statute imposes a clear duty on HHS to comply with the statutory deadlines, statute gives AHA a corresponding right to demand compliance with the deadlines, and escalation is an inadequate alternative remedy in the circumstances of this case
  - "In the end, although courts must respect the political branches and hesitate to intrude on their resolution of conflicting priorities, our ultimate obligation is to enforce the law as Congress has written it. Given this, and given the unique circumstances of this case, the clarity of the statutory duty likely will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle."

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Judicial Relief re: Appeals Backlog

American Hospital Association, et. al. v. Burwell (Case 1:14-cv-00851-JEB) (September 19, 2016)

- D.C. District Court concluded that absent any intervention the OMHA backlog at the end of FY2020 will be over 1,900,000
- Required "significant progress toward a solution" but clarified that this must mean "real movement towards statutory compliance" and not just slowing down the backlog.
- Concluded that HHS' suggested administrative fixes do not demonstrate the needed "real movement towards statutory compliance."
- The Court accepted reduction in appeal thresholds as proposed by AHA to reduce the backlog of ALJ appeals by certain intervals:
  - 30% by 2018;
  - 60% by 2019;
  - 90% by 2020;
  - 100% by 2021

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New RAC Program Enhancements

Effective May 15, 2015

- Required to maintain an overturn rate of less than 10% at the first level of appeal
  - Failure will result in CMS placing the RAC on a corrective action plan, that could include decreasing the ADR limits, or ceasing certain reviews until the problem is corrected.
- Required to maintain an accuracy rate of at least 95%.
  - Failure will result in a progressive reduction in ADR limits.
- Limited the look-back period to 6 months from the date of service for patient status reviews in cases where the hospital submits the claim within 3 months of the date of service
- Incrementally apply the ADR limits to new providers under review

Effective January 1, 2016

- ADR limits are diversified across all claim types of a facility (e.g., inpatient, outpatient) to ensure that a provider with multiple claim types is not disproportionately impacted by a RAC's review in one claim type
- ADR limits based on a provider's compliance with Medicare rules
  - Providers with low denial rates will have lower ADR limits while providers with high denial rates will have higher ADR limits
  - ADR limits will be adjusted as a provider's denial rate decreases

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New RAC Program Enhancements

October 31, 2016: CMS awarded the next round of RAC contracts to:

- **Region 1 – Performant Recovery, Inc.**
- **Region 2 – Cotiviti, LLC**
- **Region 3 – Cotiviti, LLC**
- **Region 4 – HMS Federal Solutions**
- **Region 5 – Performant Recovery, Inc.**

- RACs in Regions 1-4 will perform postpayment reviews that were made under Part A and B for all providers other than DMEPOS and home health/hospice.
- Region 5 will focus on postpayment reviews for DMEPOS and home health/hospice nationwide.

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Medicare Appeals Backlog

- HHS approach to address the backlog:
  - Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog;
  - Take administrative actions to reduce the number of pending appeals and implement new strategies to alleviate the current backlog;
  - Propose legislative reforms that provide additional funding and new authorities to address the volume of appeals

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Activities to Address Appeals Backlog

- AFIRM Act – Announced in December 2015 and not passed as of February 2017
- Settlement Conference Facilitation Pilot Program
- CMS 66% Inpatient Hospital Claim Settlement
- OMHA Case Processing Manual https://www.hhs.gov/about/agencies/omha/the-appeals-process/case-processing-manual/index.html
- MLN Matters SE1521 (May 9, 2016): For redeterminations and reconsiderations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied.

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CMS Final Rule: New Regulations to Address Backlog

- "Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures"
  - 82 Fed. Reg. 4974 (January 17, 2017)
  - Effective March 20, 2017 (Further delay possible)

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CMS Final Rule: New Regulations to Address Backlog

- **Overview of the Final Rule**
  - Reforms and changes to the Medicare appeals process to encourage efficiency;
  - All reforms support HHS' three-prong approach to addressing the increasing number of appeals and the backlog of appeals at the OMHA level of appeal;
  - Rule includes a variety of changes to language within the Code of Federal Regulations

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CMS Final Rule: New Regulations to Address Backlog

- **Major changes in the Final Rule include:**
  - Precedential authority to selected Medicare Appeals Council decisions
  - Attorney Adjudicators at OMHA
  - Submission of Evidence for Medicare appeals
  - Appointed Representatives
  - CMS Contractors participation in ALJ proceedings

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CMS Final Rule: New Regulations to Address Backlog

- **Precedential authority to Medicare Appeals Council decisions**
  - Under previous regulations, Medicare Appeals Council ("Council") decisions were binding on the parties to the particular appeal;
  - The revised regulation, 42 C.F.R. 401.109, provides the Chair of the Departmental Appeals Board ("DAB") the authority to designate a final decision of the Council as precedential;
  - Purpose: to provide appellants with consistent precedential decisions to utilize in seeking appeals, to assist appeal adjudicators at all levels of appeal by providing clear direction on common legal and policy issues and in some circumstances, factual questions.

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CMS Final Rule: New Regulations to Address Backlog

- **Precedential authority to Medicare Appeals Council decisions**
  - Application to factual issues: Where precedential decisions apply to a factual question, it would apply only in limited situations where the relevant facts are the same and the evidence presented demonstrates that the factual circumstances have not changed since the precedential decision was issued;

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CMS Final Rule: New Regulations to Address Backlog

- **Precedential authority to Medicare Appeals Council decisions**
  - Factors DAB Chair may consider in determining to designate a specific decision as precedential:
    - Primary goal is to identify Council decisions with wide applicability where the precedent is likely to materially improve predictability and consistency in decisions;
    - Whether the precedential decision would have wide applicability to a broad number of cases or if the decision analyzes a legal issue of general public interest;
    - Whether the appeal's record was fully developed at lower levels of review;

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CMS Final Rule: New Regulations to Address Backlog

- **Precedential authority to Medicare Appeals Council decisions**
  - Notice of selected precedential decisions will be provided within a reasonable amount of time after the issuance of the decision and provided through publication in the Federal Register as soon as possible to the time the decision is selected to be precedential.
- Effect on providers and suppliers:
  - Monitor for appeal strategies
  - Monitor for prospective compliance

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CMS Final Rule: New Regulations to Address Backlog

- **Attorney Adjudicators at OMHA**
  - Regulations provide authority to attorney adjudicators to render decisions when an ALJ hearing is not necessary because:
    - The decision can be issued without one;
    - To dismiss appeals when an appellant withdraws his or her request for an LJ hearing;
    - To remand certain appeals pursuant to regulatory standards or at the direction of Council;
    - To conduct reviews of QICs' and IREs' dismissals.
  - Attorney adjudicators specifically trained to handle appeals regarding issues only within the written record that do not require an oral hearing.
  - Attorney adjudicators may refer a case for an ALJ hearing if determine a hearing is warranted and the ALJ will independently determine if a hearing is necessary.

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CMS Final Rule: New Regulations to Address Backlog

- **Attorney Adjudicators at OMHA**
  - The goal is to utilize ALJs for hearing cases on the merits, including fact-finding and reaching conclusions of law;
  - Utilizing attorney adjudicators will decrease ALJ's workload by transferring non-hearing, non-substantive claims to attorneys trained in the Medicare system;
  - Any final determination, including those from an attorney adjudicator, may be appealed to the Medicare Appeals Council.

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CMS Final Rule: New Regulations to Address Backlog

- **Submission of Evidence for Medicare Appeals**
  - Current 42 C.F.R. 405.1028: Submission and Examination of New Evidence
    - Good cause requirement
    - If no good cause, the evidence is excluded from the record and not considered in reaching a decision.

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CMS Final Rule: New Regulations to Address Backlog

- **Submission of Evidence for Medicare Appeals**
  - Newly revised regulations include specific instances for when an ALJ may consider permitting introduction of new evidence:
    - Evidence is material to an issue which was not identified as a material issue prior to the issuance of the reconsideration decision;
    - The new evidence is material to an entirely new issue addressed in the reconsideration decision;
    - The party was unable to obtain the evidence prior to the reconsideration decision, and the party has supplied evidence to establish its reasonable attempts to obtain evidence prior to reconsideration;
    - The evidence was submitted before reconsideration and the party can show evidence to prove the submission and the fact that it was not included in the administrative record;
    - ALJ's discretion

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CMS Final Rule: New Regulations to Address Backlog

- **Submission of Evidence for Medicare Appeals**
  - Revised regulations will reflect that evidence submitted after reconsideration that does not meet good cause criteria will be preserved in the administrative record;
  - Purpose of the new regulations:
    - To clearly indicate that providers and suppliers should submit all evidence that is relevant to their appeal as early as in the appeal process as possible and to clarify instances where an ALJ or attorney adjudicator may find good cause for introduction of new evidence at the OMHA level.

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CMS Final Rule: New Regulations to Address Backlog

- **Appointed Representatives**
  - New regulations provide clarity regarding required information on an Appointed Representative form for beneficiaries and providers.
  - Previous Appointment of Representative form included a field that stated "Medicare Number or National Provider Identifier Number"
  - Appeals submitted on providers' behalf that included the provider's NPI were improperly dismissed or returned because the beneficiary's HICN was not included on the

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CMS Final Rule: New Regulations to Address Backlog

- **Appointed Representatives**
  - Revised regulations will specifically state that where the party appointing the representative is a beneficiary, the beneficiary's HICN must be included and where the party appointing the presentative is the provider, the provider's NPI will be included.
- Impact on Appeals Backlog
  - Unnecessary/incorrect denials cause administrative delays and waste of resources

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CMS Final Rule: New Regulations to Address Backlog

- **CMS Contractors Participation in ALJ Proceedings**
  - Current regulations permit CMS and CMS contractors to participate in ALJ hearings
    - 42 C.F.R. 405.1010: When CMS or its contractors may participate in an ALJ hearing;
    - 42 C.F.R. 405.1012: When CMS or its contractors may be a party to a hearing;

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CMS Final Rule: New Regulations to Address Backlog

- **CMS Contractors Participation in ALJ Proceedings**
  - Newly revised regulations: limit participation in ALJ hearings to either CMS or a single CMS contractor, unless ALJ finds that participation of both parties are necessary.
  - If multiple CMS entities file for participation in an ALJ hearing where one party is eligible, "only the first entity to file a response to the notice of hearing…may participate in the oral hearing."
  - CMS and/or multiple contractors may submit position papers or other written testimony for the ALJ hearing without limitation.

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Best Practices for Providers and Suppliers for Appeals

Best practices for Lower Level Appeals

- Preparation of substantive appeals early in the appeals process
  - Challenges with appeal deadlines to prevent recoupment
- Retain experts
  - Statistician
  - Clinical experts
  - Coding experts

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Best Practices for Appeals: OMHA Case Processing Manual

- OMHA Case Processing Manual available at: https://www.hhs.gov/about/agencies/omha/the-appeals-process/case-processing-manual/index.html
- Purpose: to provide direction for processing appeals at the OMHA level of adjudication and establish day-to-day procedures for carrying out adjudicative functions.

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Best Practices for Appeals: OMHA Case Processing Manual

- Useful information for appellants including:
  - Addresses and instructions for communicating with OMHA Central Options and specific ALJs
  - Information regarding OMHA's processes for handling requests and submissions;
  - Organization of the administrative record and OMHA's instructions for handling requests for the administrative record;
  - CMS and CMS Contractor Involvement in ALJ hearings;

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Best Practices for Providers and Suppliers for Appeals

Best practices for ALJ appeals

- Prominently list Medicare Appeal Number on your request
- Ensure beneficiary information matches Medicare Appeal Number
- List beneficiary's full HICN
- Include first page of QIC decision or prominently list full name of QIC
- Document Proof of Service to other parties
- Do not submit courtesy copy to QIC
- Submit only one request per Medicare Appeal Number
- Mail request via tracked mail to OMHA Central Operations
- Issue regarding evidence previously submitted lower level
- Do not attach evidentiary submissions or submit additional filings to OMHA Central Operations
- Wait until an ALJ is assigned and submit directly to ALJ

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Questions?

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