

Medicare Appeals Process: It's New But Is It Improved?¹

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As of January 1, 2006, the new regulations governing the process for appealing adverse actions related to Medicare fee-for-service claims will be fully implemented. These regulations are the product of an interim final rule (the Rule) published by the Centers for Medicare and Medicaid Services (CMS) on March 1, 2005. The Rule implements certain legislative provisions from the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000² as well as from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.³ Most importantly, providers and suppliers now will follow the same steps for appealing Part A and Part B claims, to which different appeal procedures previously applied. Part D appeals also will channel through this process.

According to CMS, the new regulations will substantially improve the efficiency of the Medicare appeals process and will reduce concerns regarding fairness and timeliness. Even so, the Rule's effect on beneficiaries, providers, and suppliers remains to be seen, especially in light of CMS' more prominent—and often adversarial—role in the process.

I. Overview of the Rule

The regulations, which apply to Part A and Part B claims, appear in new subpart I of 42 C.F.R. part 405.

A. Appeal Rights

Under the new regulations, beneficiaries, providers, and participating suppliers (and nonparticipating suppliers who have accepted assignment) can file appeals on the same grounds. As a result, providers and suppliers no longer must submit an Appointment of Representative form signed by the beneficiary for purposes of establishing party status. The Rule also abolished the amount in controversy requirement for second-level appeals and established that the monetary thresholds for ALJ and federal district court appeals will be adjusted annually for inflation.

Some confusion has arisen regarding Form CMS-20031, which is used to transfer or assign appeal rights. A beneficiary must use this form to assign his or her appeal rights to a provider or supplier that is *not* a party to the initial determination and that furnished an item or service to the beneficiary. A provider or supplier that qualifies as a party under the regulations need not obtain the beneficiary's signature on this or any other form.

B. Redetermination

Providers and suppliers will continue to have the right to appeal an initial determination to their fiscal intermediary (FI) or carrier. This

first-level appeal is now called “redetermination.” The contractor must process redeterminations within sixty days (the time limit is extended if additional evidence is submitted after requesting review), and decision notices must meet very specific requirements. For example, beneficiaries no longer will receive notices in overpayment cases involving multiple beneficiaries who have no liability at this or any other stage of the appeal process.⁴

C. Reconsideration

One of the Rule's most noteworthy changes is the addition of a uniform second-level appeal, known as “reconsideration,” conducted by qualified independent contractors (QICs). A QIC is a Medicare contractor independent of FIs and carriers that will conduct reconsiderations using a panel of healthcare professionals. QICs must issue all decisions within sixty days of receipt of a timely filed request unless additional evidence is submitted after the request for reconsideration is filed. If the QIC does not meet this deadline, the provider or supplier may escalate the appeal to an ALJ.

Under the new system, the appellant must submit all appeal requests in writing, and the QIC will conduct its review on the record (i.e., there is no opportunity for a hearing). Further, the failure to submit *all* evidence before issuance of the QIC's decision will completely prevent consideration of that evidence in all subsequent appeals, including ALJ hearings (with some limited exceptions). Going forward, appellants must prepare cases thoroughly at a very early stage in the process.

If an appeal is based on medical necessity, a panel of physicians or other appropriate healthcare professionals must consider the appeal, and the decision must be based on clinical experience, the patient's medical records, and applicable medical, technical, and scientific evidence. Further, if a claim pertains to items or services provided by a physician, a reviewing professional must be a physician (but not necessarily trained in the same specialty). The rule requires all QIC panel members to have sufficient medical, legal, and other expertise, including knowledge of the Medicare program.

Appellants should be wary of CMS' touting of the QICs' independence from CMS. Given that the QICs, like the FIs and carriers, are Medicare contractors, they may feel beholden to CMS when making reconsideration decisions.

D. ALJ Hearings and MAC Reviews

Like redeterminations and reconsiderations, ALJ and Medicare Appeals Council (MAC) decisions also are subject to a new decision time limit (generally ninety days), and appeals may be escalat-

ed if the deadlines are not met. Of even more significance is the possibility that the Medicare appeals process may become more adversarial. The new regulations formally grant ALJs the authority to ask CMS (and/or its contractors, including the FIs, carriers, and QICs) to participate in ALJ hearings; permit CMS, by its own request, to act as a party to an ALJ hearing; and allow CMS to seek MAC review of an ALJ decision. In addition, the MAC may review an ALJ decision on its own motion.

In the past, ALJs have called upon CMS and its contractors to provide input in hearings even though the regulations did not expressly allow this practice. Under the new regulations, an ALJ may request (but cannot require) CMS to participate in ALJ proceedings by filing position papers or by giving clarifying testimony on factual or policy issues. When requested to participate, CMS cannot call or cross-examine witnesses, and the appellant cannot call CMS representatives as witnesses. However, if CMS, on its own motion, serves as a party to a hearing, it can fully participate and therefore can call and cross-examine witnesses. CMS likely will participate as a party in “big box” cases that involve large overpayments or similar cases of high interest to the agency.

CMS (or its contractors) also can request MAC review of an ALJ decision. The MAC also may review an ALJ decision on its own motion.

Where CMS elects to participate, appellants will face real litigation and will have to invest more financial and human resources in the Medicare appeals process. Rather than just presenting its own affirmative case, an appellant may have to expend additional effort to rebut CMS’ preliminary motions, arguments, and witnesses. In addition, CMS’ participation could reduce the likelihood of a favorable outcome. However, providers and suppliers may find some solace in the new requirement that, when reviewing QIC overpayment decisions based on a statistical sample, an ALJ must base his or her decision on a review of *all* claims in that sample.

E. Transfer of Responsibility for ALJ Appeals

As of October 1, 2005, SSA officially transferred responsibility for ALJ appeals from SSA to DHHS. The new Office of Medicare Hearings and Appeals (OMHA), within the Office of the Secretary, is organizationally and functionally separate from CMS.⁵ The OMHA is headed by a Chief ALJ, who reports directly to the Secretary. Each of the four field offices (located in Virginia, Ohio, California, and Florida) is headed by a Managing ALJ, who reports to the Chief ALJ.

Approximately 1100 ALJs will hear appeals nationwide, and most reportedly have little or no Medicare experience. As a result, clear and concise case presentation, including a prehearing brief with all relevant legal citations to Medicare rules and regulations, will be crucial.

F. Procedural Change to the ALJ Hearing Process: Videoteleconferencing

Under the new regulations, an ALJ hearing must be conducted by videoteleconferencing (VTC). The ALJ, with the approval of the

Managing ALJ, may hold an in-person hearing only if VTC technology is not available or if “[s]pecial or extraordinary circumstances exist.” According to the Preamble to the Rule, an in-person hearing may be justified if the case presents “complex, challenging[,] or novel presentation issues.” An appellant may object to the use of VTC but must show “good cause” for any requested change. In addition, if the request is granted, the right to a decision within ninety days is lost.

The VTC requirement has critics, despite CMS’ assertion that it actually will benefit appellants because they no longer will need to travel to hearing sites. Even so, one should consider the fact that an in-person hearing may give the ALJ a better opportunity to assess witness demeanor and credibility. The VTC rules already have given rise to litigation. Two beneficiaries and an organization representing beneficiaries’ interests filed suit protesting the VTC rules because they will deprive beneficiaries of the right to an in-person hearing.⁶

G. Reopening

According to the Preamble to the Rule, CMS consolidated and clarified the reopening regulations to eliminate “longstanding confusion” about these rules. In particular, CMS sought to make clear that reopening is remedial action taken to address overpayments as well as underpayments and that human and mechanical clerical errors (including mathematical mistakes, inaccurate data entry, and denials of claims as duplicates) must be handled through the reopening rather than the appeal process. Contractors, QICs, ALJs, and the MAC all have the authority to reopen.

Under the new regulations, a party can request reopening, or a contractor can reopen on its own motion, for any reason within one year of the date of the initial determination or redetermination at issue. Reopening also may be requested by either party for “good cause” within four years. Good cause is limited to the existence of new and material evidence that was not available when the determination or decision was made and that could result in a different outcome or the evidence considered clearly shows on its face that an obvious error was made.

Finally, CMS has bolstered its ability to reopen claim determinations anytime if “fraud or similar fault” is suspected. Although the regulations always have allowed reopening in these circumstances, CMS has added the following definition of “similar fault”:

. . .to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or receive is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim. . .

According to the Preamble to the Rule, similar fault is meant to cover situations where inappropriate billing has occurred but

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enforcement authorities decide not to pursue a recovery based on fraud. Providers and suppliers should take note of this new expansive basis for reopening because it almost certainly will lead to recovery of overpayments where enforcement authorities find no evidence of fraud. In addition, this new provision will deprive providers and suppliers of a basis for disputing full recovery of overpayments based on a five-year statistical sample. In the past, many providers and suppliers successfully argued that, in the absence of fraud, carriers and FIs could not seek recovery based on a five-year statistical sample because they could only reopen claim determinations dating back four years. However, CMS makes clear in the Preamble to the Rule that contractors can rely on the similar fault provision to collect overpayments based on a five-year statistical sample.

II. Conclusion

Providers and suppliers must prepare for the possibility that the changes in the Medicare appeals process could have adverse effects given, among other things, the creation of a more prominent role for CMS in ALJ hearings and the revamped reopening process that could result in an increase in recovery of overpayments. At this point, CMS' claims of increased efficiency and fairness and improved results should be viewed with a healthy dose of skepticism.

Endnotes

¹ This article was adapted from another article authored by Ms. Lovitch, "Overhaul of the Process for Appealing Medicare Denials and Overpayments: Are Providers and Suppliers Prepared?" That article appeared in BNA's Health Care Fraud Report on May 11, 2005.

² Pub. L. No. 106-554, 114 Stat. 2763 (2000).

³ Pub. L. No. 108-173, 117 Stat. 2066 (2003).

⁴ CMS Pub. 100-04, Transmittal 97, Change Request 2620 (Feb. 6, 2004).

⁵ 70 Fed. Reg. 36325, 36386 (Jun. 23, 2005).

⁶ *Webber v. McClellan*, No. 05-at-03419 (D. Ariz., filed Dec. 22, 2005).

Chair's Column

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As if you need more reasons to attend AHLA's annual Institute on Medicare and Medicaid Payment Issues, here are two that will make the 2006 program irresistible.

First, and for the first time ever, the Regulation, Accreditation, and Payment Practice Group will be presenting "2005: the Year in Review." During this ninety-minute extended session, leaders of the RAP Practice Group will provide an overview of the major regulation, accreditation, and payment developments in 2005, and take you in depth on why these developments will affect your practice in 2006. How often do you find yourself hearing or reading bits here and there about major developments that affect your world that you pass over because of the press of other work? This comprehensive review will provide the tutorial you need on the many case law, regulatory, and JCAHO developments that you may have missed throughout the year, but need to know. This session will be held in the morning on Wednesday, March 22nd, the first day of the conference, and as such also will provide guidance on which other sessions you should attend for more detailed discussions. Don't miss it!

Second, the RAP Practice Group will once again sponsor its annual mid-year luncheon meeting. The luncheon will feature Chip Kahn, President of the Federation of American Hospitals, as speaker. The lunch also provides an opportunity to network with the leaders and members of the RAP Practice Group, and to hear about the Practice Group's work plans for the coming year. The lunch will also be held on Wednesday, March 22nd. It is available to RAP Practice Group members for \$38, and to non-members for \$43.

I look forward to seeing you there!