



# MEDICARE REPORT



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## Overhaul of the Medicare Appeals Process: Are Providers and Suppliers Prepared?

By **KAREN S. LOVITCH**

**O**n March 1, 2005, CMS published a long-awaited interim final rule<sup>1</sup> (the Rule) making sweeping changes to the process for appealing adverse actions related to Medicare fee-for-service claims. The Rule implements certain legislative provisions from the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000<sup>2</sup> (BIPA) as well as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003<sup>3</sup> (MMA). These new regulations are particularly significant because they unify the appeal processes for Part A and Part B claims, to which different appeal procedures apply until the first significant stage of implementation begins on May 1, 2005.

Other important aspects of the Rule, all of which are discussed below, include the following:

- processing of second-level appeals by a new independent entity;
- mandatory submission of all evidence early in the appeals process, except in limited circumstances;

<sup>1</sup> 70 Fed. Reg. 11420 (Mar. 8, 2005).

<sup>2</sup> Pub. L. No. 106-554, 114 Stat. 2763 (2000).

<sup>3</sup> Pub. L. No. 108-173, 117 Stat. 2066 (2003).

*Lovitch is Of Counsel in the Washington, D.C. office of Mintz, Levin, Cohn, Ferris, Glovsky & Popeo PC, practicing in the Health Section. Lovitch can be reached at (202) 434-7324 or [kslovitch@mintz.com](mailto:kslovitch@mintz.com). Lovitch would like to recognize and thank Marie Infante, JD, RN, MBA, who is a Member of Mintz Levin's Health Section, for providing valuable advice on and assistance with this article.*

■ administrative law judge (ALJ) hearings conducted via videoteleconferencing rather than in person;

■ party status for the Centers for Medicare and Medicaid Services (CMS) in ALJ hearings; and

■ substantial deference to CMS guidance for ALJs.

In light of these and other changes, providers and suppliers must take immediate action to revamp their policies and procedures for handling Medicare denials and appeals to ensure a positive result as early in the process as possible.

Currently, a provider dissatisfied with a determination on a Part A claim can seek reconsideration from the fiscal intermediary (FI). Additional levels of review are available through an ALJ employed by the Social Security Administration (SSA), the Medicare Appeals Council (MAC) of the Departmental Appeals Board, and, ultimately, a federal district court. For Part B claims, an additional level of appeal is available. Before appealing to an ALJ, a party must ask for a carrier fair hearing of an unfavorable decision at the contractor level. The new regulations will eliminate these and other differences between the two sets of appeal procedures and ostensibly are intended to increase the efficiency of the process.

In particular, as mentioned above, a new entity known as the Qualified Independent Contractor (QIC) will process all Part A and Part B second-level appeals, which are referred to in the Rule as "reconsiderations."

According to CMS, the new regulations "will produce substantial improvements in the efficiency of the Medicare claims appeal process" and "will reduce appellants' concerns over the fairness and timeliness of Medicare appeal decisions." Even so, the Rule's effect on beneficiaries, providers, and suppliers remains to be seen, especially given the fact that CMS now will have

a more prominent—and often adversarial—role in the process.

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### Initiation of Reform Under BIPA

Reform of the Medicare appeals process began several years ago with the passage of BIPA, which required the following structural and procedural changes:

- creation of a uniform process for Part A and Part B appeals,
- revision of the time frames for filing all appeals,
- implementation of fixed time frames of 30 days for issuing decisions and establishment of the right to escalate to the next level if the time frames are not met,
- use of QICs to conduct reconsiderations, and
- imposition of de novo review by the MAC of an ALJ decision made after a hearing.

Although BIPA required these modifications to apply to initial determinations made on or after October 1, 2002, CMS did not publish a Notice of Proposed Rulemaking to implement the new provisions until November 15, 2002.<sup>4</sup>

The final version of the proposed regulations was set to take effect on October 1, 2003, but numerous technical and procedural issues prevented implementation. Even the Office of Inspector General (OIG) for the Department of Health and Human Services (HHS)—a strong advocate for change in the Medicare appeals process—acknowledged the significant issues raised by BIPA's implementation.<sup>5</sup> Among other things, the OIG questioned the potential burden on an already overwhelmed appeals system and the possible increases in overall costs that could result. The OIG also voiced concern that the rigid time frames for decisions and the automatic elevation of appeals would give providers and suppliers an opportunity to “game” the system.

### Passage of MMA

The BIPA amendments to the appeals process were superseded by subsequent legislative developments when MMA was enacted on December 8, 2003. MMA, best known for its creation of Medicare Part D prescription drug coverage, also contained a number of provisions affecting the Medicare appeals process. Most importantly, MMA:

- required transfer of the functions of ALJs hearing Medicare appeals from SSA to HHS (but mandated their independence from CMS);

- created a process for expedited access to judicial review if the MAC does not have the authority to decide relevant questions of law or regulation and if there is no material issue of fact;

- mandated that all evidence must be presented at the QIC reconsideration level, unless good cause is shown;

- required QIC review of medical records in cases of medical necessity;

- imposed content requirements for appeal notices issued at all levels; and

- provided additional detail related to the QICs and reduced their number from twelve to four.

### Overview of the Rule

CMS finally moved toward implementation of the BIPA and MMA provisions by publishing the Rule in March 2005. The new regulations, which apply to both Part A and Part B claims, appear in new subpart I of 42 C.F.R. part 405. Pending full implementation, current regulations governing the Medicare appeals process, which are set forth in subparts G and H of 42 C.F.R. part 405, will remain in effect.

**Appeal Rights.** Currently, a provider or supplier may appeal an initial determination only in certain limited circumstances. 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 need to submit an Appointment of Representative form signed by the beneficiary. 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.

**Redetermination.** Providers and suppliers will continue to have the right to appeal an initial determination to the appropriate FI or carrier. This first-level appeal is now called “redetermination.” The contractor now must process redeterminations within 60 days (the time limit is extended if additional evidence is submitted after requesting review) and decision notices must meet very specific requirements. These changes already took effect on October 1, 2004.<sup>6</sup>

**Reconsideration.** One of the Rule's most noteworthy changes is the addition of a uniform second-level appeal (known as “reconsideration”) conducted by QICs. A QIC is a Medicare contractor independent of FIs and carriers that will conduct reconsiderations using a panel of health care professionals. QICs must issue all decisions within 60 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.

Providers and suppliers must take note that, under the new system, 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. Going forward, pro-

<sup>4</sup> 67 Fed. Reg. 69312 (Nov. 15, 2002).

<sup>5</sup> Office of Inspector General, Department of Health and Human Services, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-00290 (Jan. 2002).

<sup>6</sup> CMS Pub. 100-04, Transmittal 97, Change Request 2620 (Feb. 6, 2004).

viders and suppliers must prepare cases thoroughly at a very early stage in the appeal process.

If an appeal is based on medical necessity, a panel of physicians or other appropriate health care 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. The rule requires all QIC panel members to have sufficient medical, legal, and other expertise, including knowledge of the Medicare program.

In the Preamble to the Rule, CMS acknowledged a variety of very significant implementation issues. CMS has therefore decided to implement the new appeal procedures in phases. For example, because the Part A process currently does not include a second-level contractor appeal comparable to the carrier fair hearing process, CMS will begin implementation of QIC reconsiderations with appeals of FI redeterminations issued on or after May 1, 2005. The new QIC procedures will take effect for carrier redeterminations issued on or after January 1, 2006.

In recently issued guidance, CMS announced that two QICs—Maximums and First Coast Service Options—will handle appeals of FI redeterminations based on two jurisdictions (east and west).<sup>7</sup> Jurisdiction depends on the state where the service or item was rendered, except that, for chain providers, the state where its FI is located determines QIC jurisdiction. To complicate matters even further, jurisdiction of claims processed by Mutual of Omaha is based on the state where the service or item was rendered, with no exception for chain providers.

According to CMS, this new level of independent review conducted by health care professionals should reassure appellants of the independence of the reconsideration process and, over time, should lessen the need to pursue additional, higher level appeals. However, in the short-term, the QIC process could present headaches for providers and suppliers learning to navigate the new system with very little guidance from CMS or its contractors. CMS has prepared for this change by directing FIs to provide clear appeal instructions in decision notices, but, as with any new process, things may not go as smoothly as CMS anticipates. As noted by CMS, this new level of appeal for FI redeterminations also could result in an initial increase in such appeals, which could overburden the system in the near future.

Providers and suppliers also should be wary of CMS's 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.

**ALJ Hearings and MAC Reviews.** Like redeterminations and reconsiderations, ALJ and MAC decisions also are subject to a new decision time limit (90 days), and appeals may be escalated if the deadlines are not met. Of even more significance to providers and suppliers 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 contrac-

tors, including the FIs, carriers, and QICs) to participate in 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 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, however, call or cross-examine witnesses, and providers and suppliers 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.

Where CMS elects to participate, providers and suppliers 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, a provider or supplier will have to expend additional effort to rebut CMS's preliminary motions, arguments, and witnesses. In addition, CMS's participation could reduce the likelihood of a favorable outcome.

**Transfer of Responsibility for ALJ Appeals.** As mentioned above, both BIPA and MMA require the transfer of responsibility for ALJ appeals from SSA to HHS. Although the regulations do not address this issue in detail, HHS and SSA submitted a report to Congress in March 2004 explaining how the agencies will handle the transition.<sup>8</sup> According to the report, which was required under MMA, HHS will ensure the ALJs' independence from CMS by creating a new administrative office that will be organizationally and functionally separate from CMS. The ALJs will report to and be subject to the general supervision of the Secretary.

MMA requires implementation of the transition plan no earlier than July 1, 2005, and no later than October 1, 2005. According to the report, Medicare contractors will begin sending new appeal requests to HHS on July 1, 2005, and SSA will complete its processing of pending Medicare appeals (i.e., those received before July 1, 2005) no later than September 30, 2005.

Although the report repeatedly states that the ALJs will operate separately from CMS, the Rule raises questions about their independence. For instance, ALJs now must give "substantial deference" to Local Coverage Determinations, Local Medical Review Policies, and CMS guidance such as program memoranda and manual instructions. If an ALJ decides not to follow a contractor or agency policy, the decision must detail the reasons why the policy was not followed, and it will not govern future cases. Given that substantial deference is a very high legal standard, providers and suppliers must consider how a contractor or agency policy may apply in each case and prepare arguments accordingly.

<sup>8</sup> The Secretary of Health and Human Services and the Commissioner of Social Security, Report to Congress, Plan for the Transfer of Responsibility for Medicare Appeals (Mar. 2004).

<sup>7</sup> CMS Pub. 100-20, Transmittal 146, Change Request 3530 (Mar. 25, 2005).

The new regulations limit ALJ discretion in yet another way. An ALJ hearing now must be conducted by videoteleconferencing (VTC). The ALJ, with the approval of the Managing Field Office 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.” A provider or supplier 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 90 days is lost.

Given that the transfer of ALJs from SSA to HHS reportedly will result in a vast reduction in in-person hearing sites (from forty SSA offices nationwide to four HHS regional sites), ALJs likely will order hearings conducted by VTC in most cases.<sup>9</sup> In the Preamble to the Rule, CMS asserts that the VTC requirement actually benefits providers and suppliers because they no longer will need to travel to hearing sites, but providers and suppliers should consider that an in-person hearing gives the ALJ a better opportunity to assess witness demeanor and credibility.

Despite CMS’s repeated attempts to put a positive spin on the changes to the ALJ appeal process, the transition likely will be anything but smooth. In October 2004, the General Accounting Office issued a report evaluating the transition plan and finding, for a variety of reasons, that the plan likely will threaten service to

appellants.<sup>10</sup> Even so, CMS opted not to respond to the issues raised and is proceeding with its implementation plan.

## Conclusion

In the coming months, providers and suppliers should monitor the quickly evolving implementation developments. Although most providers and suppliers have a process in place for responding to Medicare denials and postpayment reviews, it must be totally revamped in light of the new regulations. In particular, providers and suppliers should have sound procedures in place to ensure that the full case for coverage is made as early as possible to minimize the need for higher-level adversarial proceedings. There are administrative costs associated with pursuing each level of appeal, and those costs increase at each subsequent level. In addition, clinical and reimbursement personnel should receive appropriate training and up-to-date information on these changes.

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 introduction of a second-level appeal conducted by a new Medicare contractor, the creation of a more prominent role for CMS in ALJ hearings, and the mandate of videoteleconferencing for ALJ hearings. At this point, CMS’s claims of increased efficiency and fairness and improved results should be viewed with a healthy dose of skepticism.

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<sup>9</sup> Robert Pear, *Medicare Change Will Limit Access to Claim Hearing*, N.Y. Times, Apr. 24, 2005.

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<sup>10</sup> General Accounting Office, *Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants*, GAO-05-45 (Oct. 2004).