Medicare Appeals: Understanding the Proposed Regulations

Presented by:
Catherine P. Baatz, M.S., J.D.
Wiggin & Dana, LLP

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Medicare Appeals: Outline

- Background
- BIPA 2000
- CMS Ruling No. 02-1
- Proposed Regulations – Key Provisions
  - Decision Making Time Frames and Escalation
  - Review of Claims by Panel of Health Care Professionals
  - Decision Letter and Documentation Requirements
  - Party Status
  - Personal Representatives
  - ALJ Review
  - DAB Review

Medicare Appeals: Background

- Original Medicare Program
  - Part A – hospital insurance program
    - Covers care provided to inpatients in hospitals, CAHs, SNFs; hospice care and some home health
  - Part B – supplemental medical insurance program
    - Covers physician's services, outpatient hospital care and other medical services not covered under Part A
- Medicare + Choice

Medicare Appeals: Background

- Original Medicare Program
  - Beneficiary obtains health services from institution, agency or person qualified to participate in Medicare program (i.e., provider or supplier)
  - Once care is provided, provider/supplier (or beneficiary) submits claim for Medicare benefits to either fiscal intermediary (Part A and certain Part B claims) or carrier (most Part B claims)

Medicare Appeals: Background

- Original Medicare Program
  - Claim should be paid if item or service is –
    - a Medicare benefit
    - reasonable and necessary
    - not otherwise excluded by statute or regulation
  - If intermediary or carrier determines services or items are not covered under Medicare program, claim is denied
  - If claim is denied, intermediary or carrier must notify provider/supplier or beneficiary and offer opportunity to appeal claim

Medicare Appeals: Background

- Historically, separate Medicare regulations govern Part A and Part B claims appeals process
  - Part A Appeals: 42 C.F.R. Part 405, subpart G (section 405.700 et seq.)
  - Part B Appeals: 42 C.F.R. Part 405, subpart H (section 405.800 et seq.)
- Medicare + Choice
  - 42 C.F.R. Part 422, subpart M

Medicare Appeals: Background

- Part A Appeals Process
  - Initial Determination by Fiscal Intermediary
  - Reconsideration by Fiscal Intermediary
    - Beneficiary, or the provider in some circumstances, may appeal the initial determination
      - 60 days to file
      - No “amount in controversy” limit
      - Time limit for processing reconsiderations: 75% in 60 days; 90% in 90 days

Medicare Appeals: Background

- Part A Appeals Process (cont.)
  - Administrative Law Judge (ALJ) Hearing
    - If dissatisfied with reconsideration, beneficiary or provider may request a hearing before an ALJ
      - 60 days to file
      - “Amount in controversy” must be at least $100
      - No time limit for processing
      - Note: ALJs are employed by SSA but adjudicate Medicare appeals under a MOU between SSA and DHHS.

Medicare Appeals: Background

- Part A Appeals Process (cont.)
  - Departmental Appeals Board (DAB)
    - If dissatisfied with ALJ decision, may request review by the DAB (Medicare Appeals Council – MAC – is responsible component of DAB)
      - 60 days to file
      - DAB may decline review
      - No “amount in controversy” limit
      - No time limit for processing

Medicare Appeals: Background

- Part A Appeals Process (cont.)
  - Federal District Court Appeals
    - MAC decisions are final decision of the Secretary of DHHS and may be appealed to Federal District Court
    - 60 days to file
    - “Amount in controversy” must be at least $1000

Medicare Appeals: Background

- Part A Appeals Process (cont.)
  - FYI - Medicare appeals regulations contain limited provisions regarding ALJ and MAC proceedings, but in general these proceedings are governed by SSA regulations at 20 C.F.R., Part 404, subpart J.

Medicare Appeals: Background

- Part B Appeals Process
  - Initial Determination by Carrier
  - Review by Carrier
    - Beneficiary and suppliers that accept assignment for Medicare claims may appeal the initial determination
      - 6 months to file
      - No “amount in controversy” limit
      - Time limit for processing reviews: 95% in 45 days

Medicare Appeals: Background

- Part B Appeals Process (cont.)
  - Fair Hearing by Carrier
    - If dissatisfied with carrier's review decision, may request a "fair hearing"
      - 6 months to file
      - "Amount in controversy" at least $100
      - Time limit for processing hearings: 90% in 120 days

Medicare Appeals: Background

- Part B Appeals Process (cont.)
  - Administrative Law Judge (ALJ) Hearing
    - If dissatisfied with reconsideration, beneficiary or supplier may request a hearing before an ALJ
      - 60 days to file
      - "Amount in controversy" must be at least $500 ($100 for home health)
      - No time limit for processing
      - Note: ALJs are employed by SSA but adjudicate Medicare appeals under a MOU between SSA and DHHS.

Medicare Appeals: Background

- Part B Appeals Process (cont.)
  - Departmental Appeals Board (DAB)
    - If dissatisfied with ALJ decision, may request review by the DAB (Medicare Appeals Council – MAC – is responsible component of DAB)
      - 60 days to file
      - DAB may decline review
      - No "amount in controversy" limit
      - No time limit for processing

Medicare Appeals: Background

- Part B Appeals Process (cont.)
  - Federal District Court Appeals
    - MAC decisions are final decision of the Secretary of DHHS and may be appealed to Federal District Court
    - 60 days to file
    - "Amount in controversy" must be at least $1000

Medicare Appeals: Background

- General Criticisms of Appeals Processes
  - Inconsistencies between the Part A and Part B procedures
  - Length of time to prosecute an administrative appeal

Medicare Appeals: BIPA 2000

- Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 ("BIPA"), Public Law 106-554
  - Imposed changes to the Medicare appeals processes
  - General goal: to bring more uniformity to the appeals procedures and to accelerate the timeframe for completing the process

Medicare Appeals: BIPA 2000

- Section 521 of BIPA amends section 1869 of the Social Security Act to revise the Medicare appeals process
- Effective for initial determinations made on or after October 1, 2002

Medicare Appeals: BIPA 2000

- A series of structural and procedural changes
- Major changes required by BIPA amendments include –
  - Establishing a uniform process for handling Medicare Part A and B appeals, including new additional level of appeal for Part A claims
  - Revising timeframes for filing a request for Part A and B appeal
  - Imposing a 30 day timeframe for certain "redeterminations" made by FIs and carriers who made initial determination

Medicare Appeals: BIPA 2000

- Requiring creation of new appeals entity (Qualified Independent Contractor – QIC) to perform reconsiderations of FIs and carriers initial determinations and redeterminations
- Allowing beneficiaries, providers, or suppliers to escalate cases to ALJ hearing if reconsiderations are not completed within 30 days
- Establishing a uniform amount in controversy threshold of $100 for appeals at ALJ level

Medicare Appeals: BIPA 2000

- Imposing 90-day time limits for ALJ and MAC appeals
- Allowing beneficiaries, providers and suppliers to escalate a case to the next level of appeal if ALJ or MAC do not meet the 90 day deadlines
- Imposing "de novo" review when the MAC reviews an ALJ decision made after a hearing

Medicare Appeals: BIPA 2000

- Requires establishment of a process for an expedited determination if a beneficiary receives a notice from a provider of services that the provider plans to terminate services or discharge the individual from the provider

Medicare Appeals: BIPA 2000

- Part A & B Appeals Process
  - Initial Determination by FI or Carrier
  - Redetermination by FI or Carrier
    - Beneficiary and certain providers/suppliers may appeal the initial determination
      - 120 days to file
      - No "amount in controversy" limit
      - Time limit for processing reviews: 30 days

Medicare Appeals: BIPA 2000

- Part A & B Appeals Process (cont.)
  - Reconsideration by QIC
    - If dissatisfied with FI's or carrier's initial or redetermination, may request a reconsideration by QIC
      - 180 days to file
      - No "amount in controversy" limit
      - Time limit for processing reconsideration: 30 days

Medicare Appeals: BIPA 2000

- Part A & B Appeals Process (cont.)
  - Administrative Law Judge (ALJ) Hearing
    - If dissatisfied with reconsideration, may request a hearing before an ALJ
      - 60 days to file
      - "Amount in controversy" must be at least $100
      - Time limit for processing: 90 days

Medicare Appeals: BIPA 2000

- Part A & B Appeals Process (cont.)
  - Departmental Appeals Board (DAB)
    - If dissatisfied with ALJ decision, may request review by the DAB (Medicare Appeals Council – MAC – is responsible component of DAB)
      - 60 days to file
      - No "amount in controversy" limit
      - Time limit for processing: 90 days

Medicare Appeals: BIPA 2000

- Part A & B Appeals Process (cont.)
  - Federal District Court Appeals
    - MAC decisions are final decision of the Secretary of DHHS and may be appealed to Federal District Court
    - 60 days to file
    - "Amount in controversy" must be at least $1000

Medicare Appeals: CMS Ruling 02-1

- CMS responsible for implementing BIPA 521 provisions regarding Medicare appeals for initial determinations made on or after October 1, 2002
- CMS recognized that it would be unable to immediately implement some of the BIPA 521 provisions by October 1, 2002
- Issued Ruling No. 02-1 on October 1, 2002

Medicare Appeals: CMS Ruling 02-1

- Purposes of Ruling No. 02-1
  - Discuss the progress made by CMS to date in implementing the BIPA 521 provisions
  - Describe criteria used to evaluate ability to implement BIPA 521 provisions
  - Explain requirements to be implemented effective October 1, 2002
  - Clarifies policies with respect to BIPA 521 provisions that cannot be implemented by October 1, 2002
  - Provides notice of administrative procedures that CMS contractors, ALJs and the MAC/DAB will follow for processing Medicare claims appeals until CMS is able to fully implement the BIPA 521 provisions

Medicare Appeals: CMS Ruling 02-1

- What did CMS do ?
  - Issued July 31, 2002 Program Memorandum (Transmittal AB-02-111) to Intermediaries and Carriers
    - "Implementation of Certain Initial Determination and Appeal Provisions within section 521 of BIPA of 2002"
      - 120 time limit for filing requests for appeal of all initial Part A determinations or Part B reviews
      - Lower amount in controversy requirement for Part B ALJ hearings ($500 → $100)

Medicare Appeals: CMS Ruling 02-1

- What did CMS do ?
  - Completed development of RFPs to solicit bids for QIC contracts
  - Developing Notice of Proposed Rulemaking to establish implementing regulations for release in Fall 2002
  - Completed phase one of a contract to develop a central appeals case tracking system
  - Revising various appeals forms
  - Revising "denial" messages to make more informative to potential appellants

Medicare Appeals: CMS Ruling 02-1

- Why is CMS unable to implement all the relevant BIPA 521 provisions?
  - To ensure uniformity and consistency, the new appeals provisions will be best developed through notice and comment rulemaking
  - Inspector General's January 2002 report: "Medicare Administrative Appeals – The Potential Impact of BIPA", OEI-04-01-00290"
    - OIG (CMS' auditors) concur that immediate implementation presents significant challenges due to large-scale structural changes and the lack of guidance or resources to ensure a smooth transition to the new system

Medicare Appeals: CMS Ruling 02-1

- Any rulemaking effort is further complicated by:
  - Uncertainty of the availability of resources
  - Possibility of further changes to the statutory appeals provisions
- Need to ensure that allocation of scarce CMS resources to carry out statutory mandate governing appeals process will not risk disruptions to other fundamental functions of the Medicare program, such as processing and payment of Medicare claims

Medicare Appeals: CMS Ruling 02-1

- What factors did CMS consider when determining the BIPA 521 provisions that it could implement on October 1, 2002 ?
  - Do the new provisions fundamentally affect an individual's right to appeal a denied claim, or do they primarily involve the applicable appeals procedures?
  - Are the provisions clear and self-explanatory?
  - Can the provisions be implemented by October 1, 2002, using existing CMS resources?

Medicare Appeals: CMS Ruling 02-1

- What factors did CMS consider when determining the BIPA 521 provisions that it could implement on October 1, 2002 ?
  - Can the provisions be implemented appropriately under the existing appeals structure (i.e., without the introduction of QICs into the administrative appeals process?
  - In the short-term, will implementation of a given provision on a stand-alone basis support, rather than undermine, Congress' statutory intent of producing more timely and accurate final decisions on Medicare claim appeals?

Medicare Appeals: CMS Ruling 02-1

- What BIPA 521 provisions did CMS implement on October 1, 2002 pursuant to CMS Ruling 02-1 ?
  - Implement the 120-day deadline for filing requests for redeterminations
    - Increases 60-days deadline for requesting Part A reconsiderations
    - Decreases 180-day deadline for requesting Part B reviews
      - To prevent hardships, CMS instructed carriers to grant extensions of up to 60 days in the filing deadline for Part B claims if time necessary to gather supporting records

Medicare Appeals: CMS Ruling 02-1

- What BIPA 521 provisions did CMS implement on October 1, 2002 pursuant to CMS Ruling 02-1 ?
  - Implement the $100 “amount in controversy” limit for requesting an ALJ hearing
    - Decrease $500 threshold for Part B appeals
    - Aggregation of claims to meet “amount in controversy” threshold continue to be governed by existing (pre-BIPA) regulations
      - 42 C.F.R. 405.740
      - 42 C.F.R. 405.817

Medicare Appeals: Proposed Regulations

- CMS published notice of proposed rule making (NPRM) to implement changes to Medicare appeals processes made be BIPA 521 provisions
  - 67 Fed. Reg. 69312 (November 15, 2002)
  - Comments received through January 14, 2003
  - No final regulations have been issued

Medicare Appeals: Key Provisions of Proposed Regulations

- Decision Making Timeframes and Escalation
  - Reduction in mandatory time frames for issuing decisions on appeals at all levels
    - Redeterminations by FI/Carrier: 30 days
      - Part A had been 60/90 days
      - Part B had been 45 days
    - Reconsiderations by QIC: 30 days
      - Part A – new level of appeal
      - Part B had been 120 days for “fair hearing” by carrier
    - Review by ALJ: 90 days
      - Previously no time limit
    - Review by DAB: 90 days
      - Previously no time limit

Medicare Appeals: Key Provisions of Proposed Regulations

- Decision Making Time Frames and Escalation
  - Appellants would be allowed to request escalation of the appeal to –
    - ALJ if the QIC does not meet the time frame
    - DAB if the ALJ does not meet the time frame
    - Federal District Court if DAB does not meet time frame and the amount in controversy is at least $1000
  - QIC, ALJ, and DAB must respond to request within 5 days by either completing its decision, if feasible, or forwarding case to next level

Medicare Appeals: Key Provisions of Proposed Regulations

- Potential Weaknesses - Decision Making Timeframes and Escalation
  - CMS proposes monitoring FIs/Carriers and evaluate performance in meeting 30 day time frame but no escalation or other remedies if redetermination not completed in 30 days

Medicare Appeals: Key Provisions of Proposed Regulations

- Potential Weaknesses - Decision Making Timeframes and Escalation
  - CMS proposes that appeal escalated from QIC to ALJ, or from ALJ to DAB, does not need to be decided within the 90 day statutory time frame (i.e., 90 days only applies to review of decisions made at level below)

Medicare Appeals: Key Provisions of Proposed Regulations

- Potential Weaknesses - Decision Making Timeframes and Escalation
  - If case escalated from QIC to ALJ, then forfeit benefit of a review by health care professionals that the QIC provides before proceeding to hearing (Note: QIC must have file reviewed if issue involves a medical necessity issue)

Medicare Appeals: Key Provisions of Proposed Regulations

- Potential Weaknesses - Decision Making Timeframes and Escalation
  - If case escalated from ALJ to DAB, then forfeit right to present case during oral hearing; in most cases DAB will issue decision based on review of written record

Medicare Appeals: Key Provisions of Proposed Regulations

- Review of Claims by Panel of Health Care Professionals
  - CMS proposes requiring QIC panel of physicians or other health care professionals to conduct reconsiderations when initial determination being appealed involved a medical necessity issue
  - CMS considering composition of "panel"
    - At least 2 physicians or health care professionals simultaneously review issue
    - At least 2 physicians or health care professionals review issue sequentially – one proposes reconsideration determination and the other reviews the proposed reconsideration determination

Medicare Appeals: Key Provisions of Proposed Regulations

- Decision Letter and Documentation Requirements
  - BIPA statute establishes specific requirements for notices following QIC reconsiderations but does not address content of redetermination notices
  - CMS proposes specific requirements for redetermination decisions produced by FIs and Carriers, including –
    - Written summary of the rationale for the redetermination decision
    - Identification of any specific missing documentation that contributed to the decision to deny the claim

Medicare Appeals: Key Provisions of Proposed Regulations

- Decision Letter and Documentation Requirements
  - Identified documentation must be submitted with the next level appeal request (i.e., QIC)
  - If not submitted to QIC but is produced later in the appeals process, must demonstrate "good cause" why information was not submitted or consideration of the documentation is precluded

Medicare Appeals: Key Provisions of Proposed Regulations

- Party Status
  - Pre-BIPA:
    - Providers may appeal initial determinations only in limited circumstances:
      - Determination involves finding that –
        - item or service was not covered because it constituted custodial care, was not reasonable and necessary, or for certain other reasons, and
        - The provider knew or could reasonably be expected to know that the service in question was not covered under Medicare

Medicare Appeals: Key Provisions of Proposed Regulations

- Party Status
  - Pre-BIPA (cont.):
    - In other circumstances, providers must act as an appointed representative of a beneficiary in order to appeal initial determinations
  - Post-BIPA:
    - Providers who have filed a claim for items or services furnished to a beneficiary would be permitted to appeal to the same extent as beneficiaries and suppliers who take assignment (i.e, may appeal at all levels)

Medicare Appeals: Key Provisions of Proposed Regulations

- Party Status
  - Assignment of Appeal Rights
    - BIPA provides that an individual's appeal rights may be assigned to a provider or supplier that furnishes the item or services

Medicare Appeals: Key Provisions of Proposed Regulations

- Party Status
  - Assignment of Appeal Rights
    - Assignment must be in writing on CMS approved form
    - Provider must waive any right to payment from the beneficiary (does not prohibit recovery of coinsurance or deductible or where beneficiary signed an advance beneficiary notice accepting responsibility for payment)
    - Beneficiary gives up party status in appeal and any further rights to appeal on behalf of self
    - Valid for the duration of the appeals process for the items or services listed on assignment form
    - CMS proposed "revocation" process

Medicare Appeals: Key Provisions of Proposed Regulations

- Personal Representatives
  - Pre-BIPA: Appointment of personal representative procedures located in SSA provisions
  - Post-BIPA: Proposed regulations set forth modified provisions governing appointment of personal representatives for purposes of claims appeals (may be applied to initial determinations in final regulations)

Medicare Appeals: Key Provisions of Proposed Regulations

- Personal Representatives
  - Do not have independent party status; take action solely on behalf of beneficiary
  - Require written appointment signed by beneficiary and representative (applies to attorney representatives too)
  - Duration of appointment:
    - Valid for life of an individual appeal
    - Valid for one year to purposes of other appeals

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - CMS had stated in the preface to the NPRM that it intends to take over responsibility of holding ALJ hearings on Medicare claims by October 1, 2003
    - Medicare Prescription Drug bills passed by House (HR.1) and Senate (S.1) in June 2003 and currently being reconciled by Congressional Conference Committee include provisions to ensure the independence of ALJs, including that such judges are in an office that is functionally and operationally separate from CMS

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - CMS as a party to hearing
    - CMS or its contractors are permitted to be a party to an ALJ hearing, unless the request for a hearing is filed by an unrepresented beneficiary (neither mandated by BIPA nor current practice)
    - CMS has sole discretion and ALJ may not require CMS to be a party
    - CMS must notify the ALJ within 10 days of after receiving notice of the hearing
    - CMS is not required to notify other parties

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - CMS as a party to hearing (cont.)
    - The addition of CMS as a party is not included in the list of "good cause" reasons for obtaining a postponement of the hearing
    - CMS may file position papers, provide testimony to clarify factual or policy issues, call or cross-examine witnesses, and submit additional evidence without any limitation

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - CMS as a "participant" in hearing
    - CMS may elect to participate in a hearing
    - CMS may file position papers, provide testimony to clarify factual or policy issues, and submit additional evidence without any limitation
    - CMS may not call or cross-examine witnesses
    - ALJ may request, but not require, CMS to "participate" in a hearing

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - Submission of Evidence
    - Parties must submit all written evidence with request for hearing, or at least 10 days of receiving hearing notice.
    - Evidence must be accompanied by a statement explaining why it was not submitted at the reconsideration level

Medicare Appeals: Key Provisions of Proposed Regulations

- ALJ Review
  - Submission of Evidence (cont.)
    - Before hearing, ALJ will consider whether appellant (but not other parties, such as CMS) had good cause for submitting evidence first at ALJ level
    - If not good cause but evidence "was of such probative value that it may have a material outcome on the case," the ALJ must remand for revised reconsideration decision

Medicare Appeals: Key Provisions of Proposed Regulations

- QIC Reconsideration
  - Deference to policies not issued pursuant to the Administrative Procedures Act
    - QIC bound by law, regulations, CMS Rulings and NCDs (same as ALJs); BIPA states that QIC not bound by LCDs, but silent on LMRPs and CMS policies
    - Proposed regulations provide that QICs must give deference to LMPs and LMRPs, and CMS program guidance (not issued pursuant to APA)
    - The appellant has burden to prove why QIC should not defer to LMPs, LMRPs, or CMS policies; QIC must include reason in decision for not applying a such policies

Medicare Appeals: Key Provisions of Proposed Regulations

- DAB Review
  - DAB must limit its review of an ALJ's actions to those issues raised by the party in the request for review, unless the appellant is an unrepresented beneficiary
    - Note: For this purpose only, a "representative" does not include a member of the beneficiary's family, a legal guardian, or an individual who routinely acts on behalf of the beneficiary, such as a family member with a power of attorney

Medicare Appeals: Key Provisions of Proposed Regulations

- DAB Review
  - Evidence is limited to "the evidence contained in the records of he proceedings before the ALJ
  - If an ALJ hearing decision decided a new issue that the parties did not address at the ALJ level, the DAB will consider any evidence related to that issue submitted with the request for review
  - If DAB finds that additional evidence is needed to resolve issues, the DAB may remand back to the ALJ

Medicare Appeals: Proposed Regulations

- Final regulations have not been issued yet
- Congress may pass additional statutory changes
- CMS is reviewing comments on proposed regulations received through January 14, 2003
- GAO Report (GAO-03-841) released October 29, 2003: "Medicare Appeals: Disparities between Requirements and Responsible Agencies' Responsibilities"