The Law Offices of
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Health Care Provider
Legal Alert

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CMS Makes Numerous Changes to the Medicare Claims Appeal Process and Proposes Changes to Medicare Cost Report Appeals and Reopenings Involving "Predicate Facts"

The Centers for Medicare & Medicaid Services ("CMS") recently issued Transmittal 2729, revising and clarifying many aspects of the process for Medicare claims appeals (the "Transmittal").[1] The Transmittal revises CMS policies in accordance with the final regulation on Medicare claims appeals promulgated in 2009.[2] Under the Medicare claims appeal procedures, Medicare beneficiaries, providers and suppliers can appeal adverse determinations regarding claims for benefits under Medicare Part A and Part B using a four-level administrative appeal process and the right to judicial review.[3] The changes implemented by the Transmittal took effect July 23, 2013, and are intended to "ensure consistency with provisions of the final rule, enhance and clarify operating instructions and language and reinstate sections that were inadvertently removed from previous manual updates."[4] We have organized the more relevant changes into four categories discussed below: (1) timing and filing; (2) appeals decisions involving multiple beneficiaries; (3) dismissals; and (4) effectuation of decisions.

In addition, CMS used the recent proposed rule on the Medicare Hospital Outpatient Prospective Payment System ("OPPS") and Ambulatory Surgical Center ("ASC") Payment System for 2014 (the "OPPS Proposed Rule")[5] to propose revisions to its policy on appeals and cost report reopenings involving "predicate facts" from a different fiscal period than the cost reporting period under review. These changes could limit a provider's ability to wage a successful appeal for issues that have arisen in previous years. CMS is accepting comments on this and other aspects of the OPPS Proposed Rule until September 6, 2013.

Please feel free to reach us at the phone number or email address to the left if you have questions about how these changes will affect your Medicare claims appeals, cost report appeals, or reopenings.

The Medicare Claims Appeal Process. Medicare payment contractors make initial Part A and Part B determinations on Medicare claims submitted for payment by Medicare beneficiaries, providers and suppliers. A party may appeal an initial determination under the uniform appeals process for Parts A and B claims. This process consists of four levels of administrative appeals. The first level of appeal is a redetermination made by the Medicare administrative contractor. The second administrative appeal, or reconsideration, is conducted by a qualified independent contractor ("QIC"). An unfavorable decision at the

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second level may be appealed by requesting a hearing before an Administrative Law Judge ("ALJ"). A party who is dissatisfied with the decision of the ALJ may request the Departmental Appeals Board's Medicare Appeals Council to review the case. Following a final agency decision by the Medicare Appeals Council, a party may seek judicial review by the Federal district courts.

Timing and Filing. The time limit for filing each of the four levels of administrative appeals varies. The first level appeal is **redetermination**. A request for redetermination must be made within 120 days from the date of receipt of the Medicare Summary Notice ("MSN") or Remittance Advice ("RA"), although it must be filed within 30 days to stay recoupment of an overpayment. The Transmittal clarifies that notice of the initial determined is presumed to be received five days after the date of the MSN or RA, absent evidence to the contrary. If the filing deadline for a redetermination ends on a Saturday, Sunday, legal holiday, or any other non-workday, the filing deadline is the following workday. Providers and suppliers may continue to request a redetermination by filing a completed Form CMS-20027 or a signed letter with the identifying information specified by regulation.

Because a redetermination is intended to be an independent review of an initial determination, the individual performing the redetermination cannot be the same individual who made the initial determination. The Transmittal contains additional guidance regarding how contractors should handle incomplete requests for redetermination, as well as multiple requests for redetermination for the same item or service. Contractors must mail a written decision unless CMS has approved the use of a secure Internet portal.

At the second level of appeal, **QIC Reconsideration**, a request for reconsideration by the QIC must be filed 180 days from the date of receipt of the notice of redetermination, although it must be filed within 60 days to continue to stay recoupment of an overpayment. The Transmittal adds that if a party requests QIC review of a contractor's dismissal of a request for redetermination, the time limit for filing is 60 days from the date of receipt of the contractor's dismissal notice. CMS also included further clarifications regarding QIC case file preparation and QIC jurisdiction.

An **ALJ Hearing** is the third level of appeal. A request for review by an ALJ must be made within 60 days from the date of receipt of the reconsideration notice. This is the only opportunity to have a hearing on the claim denial, present supporting testimony by witnesses (*e.g.*, a physician), and otherwise interact with the reviewer on the record. In our experience, this level of the appeal process provides the best opportunity to obtain a favorable decision. The Transmittal clarifies that the payment contractor will only effectuate an ALJ decision based on documentation received by the Administrative QIC ("AdQIC"). The AdQIC operates under a contract with CMS to review ALJ decisions for possible agency referral to the Medicare Appeals Council and fields all Original Medicare (Part A and Part B) claim case files and decisions from ALJs at the Office of Medicare Hearings and Appeals ("OMHA") field offices.

At the fourth level of appeal, a party may request review of the ALJ's decision by the **Medicare Appeals Council**. A request for review by the Medicare Appeals Council must be made within 60 days from the date of receipt of the ALJ's decision. The Transmittal provides new guidance regarding the Medicare Appeals Council review. If a party requests that the Medicare Appeals Council review an ALJ's decision, the Medicare Appeals Council must conduct a *de novo* review. This means that the Medicare Appeals Council will render a new decision based on the record and the hearing, without giving weight to an earlier decision. Moreover, the Medicare Appeals Council may decide *on its own motion* to review

a decision or dismissal issued by an ALJ within 60 days after the date of the hearing decision or dismissal. The Transmittal also allows CMS to refer a case to the Medicare Appeals Council to consider under its motion review authority, provided that it does so within 60 days after the date of the decision or dismissal. The AdQIC is responsible for reviewing decisions issued by ALJs and determining whether to make an agency referral.

A party who is dissatisfied with the final agency decision of the Medicare Appeals Council and satisfies the minimum amount in controversy requirement may request **judicial review** in Federal court. This request must be made within 60 days from the date of receipt of the Medicare Appeals Council decision. The Transmittal clarifies that if a party files a request for judicial review with a contractor, the contractor must immediately notify the appellant that the complaint must be filed with the appropriate U.S. District Court. The appellant, however, is responsible for determining where the complaint must be filed.

Late Appeals. As a general rule, appeals that are filed later than the number of days specified above will not be processed and the payment denial can no longer be challenged. This makes it imperative that providers have a trusted system for preparing, filing and tracking Medicare appeals either internally or by using a qualified appeal representative. In rare situations, an appeal that is filed late will be processed if "good cause" can be shown. The Transmittal clarifies that if an appeal request is filed late, the contractor *may* extend the time limit for filing an appeal for "good cause." Good cause may be found when the record clearly shows, or does not negate an assertion that a delay in filing was due to unavoidable circumstances beyond the provider's control or incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources. "Unavoidable circumstances" include situations that are beyond the provider, physician or supplier's control, such as floods, fires, tornados, and other natural disasters.[6] "Official sources" include CMS, the Medicare contractor, or the Social Security Administration.[7] Importantly, the Transmittal notes that failure of a billing company or other consultant retained by the provider, physician, or supplier to timely submit appeals or other information does *not* constitute good cause for a late filing.

If a contractor dismisses a late redetermination request where there is insufficient or no explanation for the late filing, the dismissal letter must explain that the late party can either: (1) provide an explanation for the late filing within 6 months of the dismissal of the redetermination request and request that the contractor vacate the dismissal; or (2) file a request for review by the QIC within 60 days of the date of receipt of the dismissal notice. If a party submits a request to vacate the contractor's dismissal that contains sufficient evidence or other documentation to support a finding for good cause, the contractor may make a favorable good cause determination and vacate the prior dismissal action. If the contractor does not find good cause to vacate the dismissal, the dismissal will remain in effect. The party may not appeal this finding, but does retain the right to request a QIC review of the contractor's dismissal action. Requests for the QIC review of a contractor's dismissal action must be received by the QIC within 60 days of the date of receipt of the dismissal notice. These options provide another opportunity for providers to reestablish claims appeals when they can show good cause for the late filing.

Appeals Decisions Involving Multiple Beneficiaries. CMS has added new provisions to the manual that address appeals of overpayments involving multiple beneficiaries with a single account receivable and appeals involving claims of multiple beneficiaries. If an overpayment with a single account receivable includes claims for multiple beneficiaries, the contractor may issue one decision letter that includes information specific to the claims for each

beneficiary. Where an appeal involves claims of multiple beneficiaries but more than one account receivable, the contractor may either issue a separate decision letter for each beneficiary (*i.e.*, as a split appeal) or issue a single letter with attachments for each separate claim. These changes allow for more efficient and cost-effective appeals by "grouping" multiple Medicare claims in one appeal request, provided that each claim is within the timeframe for a valid appeal.

Dismissals. The Transmittal revises the required content of dismissal letters issued by contractors. A dismissal notice must include the reason for the dismissal and inform parties that they may either request that the contractor vacate the dismissal or request a QIC reconsideration of the dismissal. If a party submits an incomplete request for redetermination and the contractor issues a dismissal notice, the party may request that the dismissal be vacated, appeal the dismissal, or refile the request if any time remains in the filing period. The Transmittal also updates the model dismissal notices, which are included as attachments to the Transmittal. For dismissals at the Medicare Appeals Council level, the Council may dismiss a request for any reason the ALJ could have dismissed a request for hearing, as well as any agency referral requests, if appropriate.

Effectuation of Decisions. The Transmittal states that Medicare payment contractors are responsible for effectuating redetermination decisions. As part of this responsibility, the contractor must effectuate within 30 calendar days of the date of decision, a fully or partially favorable redetermination decision that gives a specific amount to be paid. If the payment amount must be computed or recomputed, the contractor must effectuate within 30 days after the payment amount is determined, which should be no later than 30 calendar days after the date of the decision.

The Transmittal also addresses QIC remands and reconsideration. CMS now requires that payment contractors resolve QIC remands within 60 calendar days of receipt of the remand order from the QIC. If a QIC reconsideration decision is favorable, but the payment amount must be computed or recomputed, the contractor must effectuate the decision within 30 days after the payment amount is determined. If the decision is unfavorable, but there is a change in liability, the contractor must effectuate within 30 calendar days of receipt of the QIC's effectuation notice.

CMS also clarified the role of the AdQIC in the appeals process, including effectuation time limits and responsibilities of the ALJ. For example, a contractor must effectuate within 30 calendar days of receipt of an effectuation notice from the AdQIC, if the ALJ decision is fully or partially favorable and gives a specific amount to be paid.

Proposed Changes to Medicare Cost Report Appeals and Reopenings Involving "Predicate Facts." The OPPS Proposed Rule includes proposed changes to cost report appeals and reopenings involving factual determinations from a previous cost reporting period, or "predicate facts."[8] Currently, a provider may challenge an intermediary's reimbursement determination by filing an appeal within 180 days of the Notice of Program Reimbursement ("NPR") to the Provider Reimbursement Review Board (PRRB) or, if the amount in controversy is relatively small, to the intermediary hearing officer(s). Alternatively, the provider may request that the intermediary reopen the NPR.[9] In addition, the intermediary may initiate a reopening of the NPR on its own motion. Reopening must be requested by the provider, or reopened by the intermediary, within 3 years of the NPR.[10]

In many instances, a factual matter arises in, or is determined for, a *different* fiscal period than the cost reporting period at issue. CMS refers to such facts as "predicate facts." CMS defines a predicate fact as:

> a factual matter that arose in or was determined for a cost reporting period that predates the period at issue (in an appeal filed, or a reopening requested by a provider or initiated by an intermediary…), and such factual matter was used in determining an aspect of the provider's reimbursement for a later cost reporting period.[11]

For example, a predicate fact may be a cost during a base period that is used to determine reimbursement or a target amount in a subsequent cost reporting period.

The OPPS Proposed Rule would allow a change in a predicate fact, or a change in the application of a predicate fact in *only* two situations: (1) if a specific statute, regulation, or other legal provision permits reauditing, revising or similar actions changing predicate facts; or (2) if there has been a timely appeal or reopening of the NPR for the cost reporting period in which the predicate fact *first* arose, or the NPR for the period for which such predicate fact was *first* determined by the Medicare payment contractor. This change would apply to future *and current* (pending) intermediary determinations, appeals and reopenings. CMS is "proposing that it be effective for any intermediary determination issued on or after the effective date of the final rule, and for any appeals or reopenings (or requests for reopening) that are pending on or after the effective date of the final rule, even if the intermediary determination (at issue in such an appeal or reopening) preceded the effective date of the final rule." CMS believes that such a change is not retroactive or impermissibly retroactive. Once the 3-year reopening period has expired, neither the provider nor the payment contractor would be allowed to change a predicate fact for reimbursement purposes.

In the preamble to the OPPS Proposed Rule, CMS articulated its belief that this policy furthers the interests of both providers and the agency in maintaining the finality of intermediary determinations. CMS states that allowing the appeal and reopening of a predicate fact after the expiration of the 3-year reopening period may result in inconsistent intermediary determinations on a reimbursement matter recurring in different fiscal periods for the same provider or in intermediary determinations contrary to Medicare law and policy. CMS also noted its disagreement with the decision in *Kaiser Foundation Hospitals v. Sebelius*,[12] in which the D.C. Circuit Court determined that providers could appeal predicate facts used to determine their reimbursement in later fiscal periods even though such predicate facts were not timely appealed or reopened for the periods when they first arose or were determined by the intermediary.[13] The predicate facts at issue in *Kaiser Foundation Hospitals* were the teaching hospitals' resident full-time equivalent (FTE) counts for their 1996 cost reporting periods. CMS clearly did not like the court's decision and is using this proposed rule as an opportunity to amend the regulations so that providers cannot use this tactic in other appeals and reopenings. CMS is considering similar amendments to its regulations governing intermediary and PRRB appeals. CMS is requesting public comments on whether to amend these additional regulations. Comments may be submitted through **September 6, 2013**. CMS has indicated that a final rule will be issued by November 1, 2013.

Impact on Health Care Providers. The Medicare claims appeal process is governed by strict rules on when, where and how to file appeals. CMS has expanded these rules in an attempt to add clarity by issuing the Transmittal,

which thoroughly revised chapter 29 of the Medicare Claims Processing Manual. Providers will need to adhere to these new requirements when challenging adverse claims determinations through the Medicare claims appeal process. In addition, the changes that CMS is proposing to the regulations on Medicare cost report reopenings may prevent providers from successfully challenging payment determinations by disputed facts in earlier cost reporting periods. This could effectively foreclose a provider's right to due process in many cases that involve issues such as base period costs if the 3-year reopening period has closed. We expect that CMS will make similar changes to the regulations on Medicare appeals. Providers should be aware of these changes when filing new appeals or requesting reopenings, and with respect to pending appeals and reopenings. We encourage providers to submit comments to the OPPS Proposed Rule if they receive reimbursement based on factual determinations in earlier years.

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[1] *See* Medicare Claims Processing Manual (CMS-Pub. 100-04), Transmittal 2729, CR 7840 (June 21, 2013).
[2] *See* 74 Fed. Reg. 65,296 (Dec. 9, 2009).
[3] Transmittal, p. 6.
[4] *Id.*
[5] 78 Fed. Reg. 43,534 (July 19, 2013).
[6] *See* Transmittal, pg. 27, revising Medicare Claims Processing Manual § 240.3.
[7] *Id.*
[8] CY 2014 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals, CMS 1601-P, 611 (July 8, 2013).
[9] 42 C.F.R. § 405.1885.
[10] 42 C.F.R. § 405.1885(b).
[11] 42 C.F.R. § 405.1885(a)(1)(iii).
[12] 708 F.3d 226 (D.C. Cir. 2013).
[13] *See* 78 Fed. Reg. at 43,683.

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located one block from The White House and just minutes from the Department of Health and Human Services and Congressional offices, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 15 years of experience with the array of legal issues facing health care providers.

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