Recent Changes Impact Appeal of Medicare Denials and Reimbursement Strategies

Executive Summary: A recent CMS ruling may give healthcare providers greater flexibility in dealing with Medicare audits.

Background

Recovery Audit Contractors (“RACs”) and other Centers for Medicare and Medicaid Services (CMS) contractors are charged with identifying overpayments made by Medicare to healthcare providers. However, with the increase in RAC and other government audits, it is clear that the Medicare appeals staff have had to manage a significantly larger volume of cases than anticipated, especially concerning appeals regarding the medical necessity of hospital inpatient admissions payable under Medicare Part A. We understand that hospitals are struggling with the financial impact of managing these audits and denials. We know that providers have been appealing wholesale denials and CMS has indicated that the volume of cases is overwhelming its appeals staff and delaying cases. Moreover, we have seen an increase in the number of cases being remanded, further delaying payment refunds to hospitals.

Indeed, Administrative Law Judges (“ALJs”) remanded cases that were denied payment under Medicare Part A back to contractors involved at lower levels of the appeals process (i.e., to a Qualified Independent Contractor ("QIC") or to the Medicare Administrative Contractor ("MAC") directing that the QIC or MAC calculate an appropriate Medicare Part B payment to hospitals for needed outpatient treatments. Staff reported that ALJs were remanding cases to ensure providers had the opportunity to review re-calculated Part B payments earlier in the appeals process. Unfortunately, there are no "deadlines" for remands to be re-reviewed.

Concerns about the Medicare appeals process and administrative burdens placed on both adjudicators and providers have been building over the last year, and recently, important changes were announced that impact revenue strategies for hospitals, in particular.

The Administrator’s March 13th Ruling

Citing “numerous operational difficulties” regarding decisions that order “expanded” Part B payment to hospitals in the event the Part A reimbursement for inpatient care is denied, CMS Acting Administrator, Marilyn Tavenner, issued an Administrator’s Ruling (the “Ruling”) (“CMS-1455-R”) on March 13, 2013 that may be helpful, at least in the interim, for hospitals.

In CMS’ words, the Ruling “clarifies” that although contractors are bound to effectuate decisions issued by ALJs and the Departmental Appeals Board Medicare Appeals Council (the “DAB-MAC”), some decisions have been “contrary to existing CMS policy.” Despite its apparent disagreement with these decisions, CMS ultimately “acquiesces” to the approach taken in cases where expanded coverage was allowed for Part B services. CMS offers the Ruling to establish a process for hospitals to request payment under Part B for reasonable and necessary services, not merely the limited ancillary reimbursement.

Importantly, the Ruling applies to Part A hospital inpatient claims that were denied as not reasonable and medically necessary if the denial was made: 1) while the Ruling is in effect; 2) prior to the effective date of the Ruling if the timeframe to file an appeal has not expired; or 3) prior to the effective date of the Ruling if an appeal is pending.
For now, the Ruling gives hospitals a right to withdraw pending appeals of denied Part A claims and instead submit a Part B claim, with services to be submitted either on a Part B outpatient claim or a Part B inpatient claim. Requests for withdrawal of pending denied Part A claims must be sent to the adjudicator with whom the appeal is currently pending, except for claims that were remanded by ALJs to the QIC. In the case of remanded claims, the QIC will return such claims to the ALJ for adjudication within the limited scope of the denied Part A claim. In either case, hospitals will have 180 days either from the date of receipt of an appeal dismissal notice or from the date of receipt of the final or binding decision to submit a claim for “expanded” Part B reimbursement. Importantly, CMS emphasizes that beneficiary co-pay obligations are in place should providers take advantage of this option.

Although the Ruling does not require hospitals to withdraw cases and accept the “expanded” Part B reimbursement, there may be advantages to doing so, given the delays in the appeals and processing payments for providers. In addition, the Ruling continues, specifying that if hospitals do not opt for the new Part B payment and continue to pursue appeals, in the event ALJs decide that the Part A inpatient admission is inappropriate, they cannot any order that any payment be issued under Part B.

Although there is disagreement as to the validity of CMS’ position on the scope of the ALJ’s authority, CMS justifies its directive, stating that the scope of an ALJ review is for the specific Part A inpatient claim(s) at issue. Accordingly, regardless of whether medically necessary services were provided, in cases of denial of an inpatient admission, CMS asserts that the ALJ can only order full Part A reimbursement or wholly deny payment.

As discussed below, CMS has issued a proposed a new regulation on this issue, asserting that once the new rule is in place, the “enhanced” Part B payment described in the Ruling will no longer be available to providers who have appealed denied claims.

**Proposed Rule**

Indeed, on March 18th, CMS published a Proposed A/B Rule that would revise Medicare Part B billing policies. Specifically, under the Proposed A/B Rule, the enhanced Part B payment would be allowed when an inpatient hospitalization is determined by CMS, a contractor, or a hospital upon self audit, to have not been medically necessary. However, the hospital will have to file a corrected claim within 12 months of the date of service to be reimbursed under this regulation. CMS made clear that although contractors and the RAC may review claims that have been filed up to three years after the date of service, if an inpatient claim is audited and denied after the timely filing deadline, the provider cannot be reimbursed for any services under Medicare Part B, even if all care was deemed medically necessary.

The specific services excluded from rebilling under Part B in the Proposed A/B Rule include services that by statute, Medicare definition, or standard Healthcare Common Procedure Coding System (HCPCS) code are defined as outpatient services such as outpatient visits, emergency department visits and observation services because these services are provided to hospital outpatients only.

Although hospitals that self-audit claims quickly or have claims audited under a prepayment review program may benefit under the Proposed A/B Rule, CMS makes clear its position that there is a limited time period to use this option. Providers have until May 17, 2013 to comment on the regulation and CMS must address public concerns in formulating its final rule.

**Update from the Office of Medicare Hearings and Appeals**

That CMS is overwhelmed by the appeals process is evident in the delays in processing cases as well as the remands and other comments from ALJ staff. Hospital providers faced with a “Hobson’s choice” of accepting at least some payment now, rather than additional delays or legal challenges to CMS’ Ruling, may understandably opt for rebilling claims as

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1 On March 22, 2013, CMS released Change Request 8185 (Transmittal 1203) with an effective date of March 13, 2013 and an implementation date of July 1, 2013, in order to give specific guidance for rebilling claims under Part B. A concurrent MLN article explaining the Transmittal is available at: [www.cms.hhs.gov/MLNMattersArticles](http://www.cms.hhs.gov/MLNMattersArticles). Hospitals submitting Part B inpatient claims are instructed to include a condition code “W2” on the claim as an attestation that the claim is being rebilled and that no appeal is pending to avoid duplicate payments.
offered. Nevertheless, it is clear that the volume of appeals has overwhelmed contractors and ALJs and must be addressed.

Indeed, Judge Nancy Griswold, Chief Administrative Law Judge for the Office of Medicare Hearings and Appeals (“OMHA”) oversees the third level review for Medicare appeals within the United States Department of Health and Human Services and recently commented on the process. In her comments at the American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues in Baltimore, Maryland in March, Judge Griswold stated that her office anticipated (and therefore planned for) appeal volumes would be around 1500 to 2000 per week to be filed at the ALJ level. Continuing, she reported that the appeals volume increased in mid-March to 6600 claims in one week, which significantly exceeds OMHA staffing levels. She reported that Part A claims represent 50% of the appeals that OMHA receives.

The increase in 2013 is further compounded given the reported trends since the RAC program was nationally installed. In fiscal year 2012, there was a 119% increase in appeals filed over the prior year, and in fiscal year 2013, there was a 147% increase. In 2012, approximately 6.2 appeals were assigned per ALJ each week and in 2013, 12.6 appeals are assigned per ALJ. On average, for each ALJ last year, there were 483 appeals pending. This year, there is an average of 881 cases pending for each ALJ.

Griswold reported that OMHA requested additional funding, but had not received it yet. Currently, there are only 60 ALJs in four offices handling appeals. On average, Griswold reported that the average processing time for each case is 166 days. Griswold stated that OMHA is moving to standardize the process of appeals with electronic processing of case files. Although the delays due to understaffing cannot be avoided, providers need to be certain that a beneficiary is copied on filings before the ALJ to avoid procedural delays.

As for the new Ruling, Judge Griswold stated that if Providers wish to request an appeal be withdrawn, there is a new form posted on the OMHA website at www.hhs.gov/omha/Data/cmsruling.html and at www.hhs.gov/omha/Data/cmsruling.pdf. Judge Griswold added that if cases have not been assigned to and received an ALJ case number, then providers should place the QIC Medicare appeal number on the withdrawal form which should be sent to the centralized docketing address in Cleveland, Ohio.

**Possible Relief For Providers with New Proposed Legislation**

Although the provider community has welcomed aspects of CMS’ modifications to its programs, it seems that Congress has heard the concerns voiced and may be willing to act. The Medicare Audit Improvement Act (the “Act”) bipartisan bill was reintroduced in March by Congressman Sam Graves (R-MO) and Adam Schiff (D-CA) just days after CMS issued the Ruling and Proposed A/B Rule. Importantly, the Act would amend the Medicare Modernization Act of 2003 to address numerous issues surrounding the RAC program. For example, the Act proposes a hard cap on RAC Additional Document Requests (“ADRs”) to two percent of hospital claims with a maximum of 500 ADRs per 45 days. Providers voice support for this measure which would help mitigate at least some administrative burdens. “While I believe we must continue to identify and correct verifiable fraud, hospitals have been buried in the administrative burdens put on them by Medicare audit contractors,” said Graves. “Doctors and nurses should be focused on caring for patients, not trying to comply with the ever-increasing requests for documents.” The Act would also improve RAC performance by assessing penalties if RACs do not adhere to basic program requirements.

**Conclusion**

"Medical necessity" is often a far more complex matter than auditors recognize, and providers must often expend considerable time and effort to ensure that Contractors do not inappropriately recover funds from them. It is clear that the appeals process is not working as contemplated, impacting all providers. Moreover, it is clear that there is no “black and white” rule as to what constitutes inpatient versus outpatient admission in a hospital under CMS’ and the RAC’s review. Ultimately, it is important for providers to comment on the Proposed A/B Rule to ensure that their perspectives are heard. Because each patient has unique considerations for his or her care, it may be that the admission decision and status assignment remain a peer review process, with input from treating providers as to the necessity of care. CMS itself
acknowledges that this is a “gray” area, so a process whereby providers can be paid for all necessary care delivered would appear reasonable.

Providers who have in good faith provided needed care to patients should consider appealing adverse determinations. It remains to be seen whether ALJs will limit their scope of review in cases to the “all or none” paradigm CMS asserts must be used.

Because hospitals have experienced significant delays in restoring improperly recouped funds, providers may consider following the procedures outlined by CMS in the Ruling to mitigate damages. Although it is clear that CMS believes that ALJ orders to reimburse hospitals for all services provided, whether under Parts A or B, are improper, it remains to be seen whether the agency can confine the scope of review as offered in the proposed regulation. Legal authorities may enable hospitals to continue to be reimbursed as ALJs have ordered, particularly given CMS’ inability to articulate and effectuate clear standards for medical necessity reviews of inpatient admissions.

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If you have any questions about the issues raised in this alert, please contact Womble Carlyle Healthcare Industry Team attorneys Tracy Field, Tom Stukes and Deonys de Cárdenas or consulting physician Charles Whigham, MD.

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