

MEDICARE APPEALS UPDATE AND WHAT CMS IS DOING TO MAKE THE APPEAL PROCESS MORE ADVERSARIAL

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Several decisions recently issued by the Provider Reimbursement Review Board ("PRRB"), the CMS Administrator and the federal courts highlight the many challenges that hospitals and other providers encounter when appealing Medicare reimbursement denied on a cost report. These decisions address a variety of topics, including requirements for claiming bad debts on cost reports and the rules for appealing cost report determinations to the PRRB. Recent decisions also address Medicare reimbursement denied on claims review in the context of statistical sampling and reopenings. CMS also recently issued a transmittal requiring increased participation by Medicare contractors at ALJ hearings to make the claim appeal process more adversarial.

Please feel free to reach us at the phone number or email address to the left if you have questions about how these decision or the CMS transmittal affect your facility, or for assistance in challenging Medicare reimbursement denials.

Contractor Participation in Claim Appeals. On September 26, 2014, CMS issued Transmittal 543, titled "Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings." The transmittal updates chapter 3 of the Medicare Program Integrity Manual, instructing contractors to increase their participation in the claims appeal process, especially at the ALJ level. The changes in the transmittal apply to Medicare Administrative Contractors ("MACs"), Recovery Audit Contractors ("RACs"), Zone Program Integrity Contractors ("ZPICs"), the Comprehensive Error Rate Testing ("CERT") contractor, and the Supplemental Medical Review Contractor ("SMRC"). Effective October 27, 2014, the new manual provisions require contractors to establish a process to receive notices of ALJ appeals from the Qualified Independent Contractor ("QIC") in cases where their own claim determination is at issue, or they had some other responsibility over the claim determination. Upon receipt, a physician at the contractor must evaluate the appeal and decide whether the contractor will take part in the hearing as a "party" or a "participant." The factors that contractors are to consider when deciding whether to take part in the hearing include policy implications, amount in controversy, source of the denial, program integrity matters, and whether it is a recurring issue at the ALJ level. To participate as a party, the contractor is first required to obtain approval from CMS. If approved as a party, the contractor may file position papers, call witnesses, cross examine

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witnesses, and request discovery. If not approved by CMS as a party, the contractor may still act as a “participant” at the ALJ hearing. As a participant, the contractor may file a position paper and provide testimony, but may not call or cross examine witnesses.

CMS is clearly trying to encourage greater participation by Medicare contractors in the claims appeal process, particularly at the ALJ hearing. In our experience, contractors rarely participate or act as a party to the appeal before an ALJ. However, the enhanced coordination between the QIC and the original contractor that denied payment, and the new requirements to review cases for participation, as directed by this transmittal, could increase the rate of participation at the ALJ hearing. As a result, we expect that more ALJ hearings will be adversarial. Moreover, the transmittal notes that the contractor is permitted to use an attorney, in place of the physician, as the individual representing the contractor. Therefore, these changes to the manual make it even more important for providers to consider designating an experienced attorney as its appeal representation.

Bad Debt – “Must Bill” Policy. The “must bill” policy requires that providers bill state Medicaid programs for dual eligible deductibles and coinsurance amounts and obtain a remittance advice (“RA”) before the debt may be claimed on the provider’s cost report as bad debt. The “must bill” policy was addressed in recent decisions from the PRRB and the CMS Administrator. In Ashton Hall Nursing & Rehab Center v. BlueCross BlueShield Association/Novitas Solutions, Inc.,¹ the provider did not submit bills to the state and obtain RAs because the Pennsylvania Medicaid billing system did not have the capability to accept and process coinsurance bills until July 1, 2004. The PRRB held that the “must bill” policy should not apply to the claims during the period when the state was unable to process and issue RAs. However, the CMS Administrator selected this decision for review and reversed the Board. The Administrator held that the “must bill” policy required the provider to obtain RAs to claim dual eligible bad debts, even when the state had no process to accept the claims and issue the RAs.

In Accord Health 2005 Crossover Bad Debts Group v. BlueCross BlueShield Association/Novitas Solutions, Inc.,² the provider argued before the PRRB that it completed a reasonable collection effort when it compared the Medicare payment with the state’s Medicaid per diem rate and decided not to bill the state because the state did not pay crossover coinsurance amounts when the Medicare payment exceeded the Medicaid per diem rate. The Board held that it was proper for the intermediary to exclude these bad debts because the provider did not determine whether any of the amounts at issue were associated with Qualified Medicare Beneficiaries (“QMBs”) and that the “must bill” policy required that the state be billed for QMBs.

The “must bill” policy was also upheld in Maine Medical Center v. Sebelius, a recent decision from the U.S. District Court for the District of Maine where the Court reviewed the Secretary’s decision to deny dual eligible bad debts when the provider did not obtain Medicaid RAs from the state of Maine.³ The Court found that the provider could not obtain RAs due to a “problem with the state’s claims processing system.” The provider attempted to submit Medicaid eligibility data to support its crossover bad debts, but the intermediary would not accept this documentation as an alternative to RAs.

The Court determined that the Secretary has the authority to implement the “must bill” policy, the hold harmless provision of JSM-370 did not apply, and the Secretary’s application of the “must bill” policy where the state failed to issue RAs was “neither plainly erroneous nor inconsistent with the applicable regulations.” The Court observed that the “must bill” policy is a “bright-line rule based on sound considerations relating to the administration of Medicare.”

The above decisions demonstrate that CMS and the intermediaries continue to take an absolute approach to the “must bill” policy for dual eligible bad debts. Moreover, the facts in these cases were not strong enough to persuade the courts to decide that the agency’s application of the “must bill” policy was arbitrary.

Bad Debt – Outside Collection Agencies. In three recent cases, the PRRB reviewed intermediaries’ determinations denying bad debts that were still pending at an outside collection agency. The Board’s decisions in these cases turned on the application of the Bad Debt Moratorium. The Bad Debt Moratorium states that CMS cannot change its bad debt policy from the policy that was in effect on August 1, 1987 and CMS cannot require a provider to change the bad debt procedures that the provider had in place on August 1, 1987.

In two of the cases, the Board held that the intermediary’s adjustments denying bad debts for cost-sharing amounts not yet returned from the outside collection agency were proper because this treatment of bad debt was consistent with the bad debt rules in place on August 1, 1987.⁴ According to the Board, the accounts here could not be proven worthless with no likelihood of recovery until they were returned by the outside collection agency.

In a third case involving similar facts, the Board held that a provider could claim bad debts on its cost report even if it was still pending with an outside collection agency.⁵ This case required a different outcome because the Board determined that the intermediary’s treatment of the bad debts violated the Bad Debt Moratorium’s prohibition on requiring a provider to change its bad debt collection policy that was in effect on August 1, 1987. In this case, the intermediary conceded that this type of bad debt was allowed at the time the Bad Debt Moratorium was enacted.

Bad Debt – Reasonable Collection Efforts. In Cooper Hospital v. BlueCross BlueShield Association/Novitas Solutions, Inc.,⁶ the PRRB addressed two issues related to reasonable collection efforts and writing off Medicare bad debt. First, the Board determined the intermediary acted properly when it denied bad debts associated with accounts in which the provider failed to follow its written bad debt collection policy. The provider’s policy stated that phone calls were to be made on accounts above certain dollar limits. Because the phone calls were not made, the Board determined that the provider failed to make “reasonable and customary attempts to collect” before the bad debt was written off and therefore violated the regulations on documentation of bad debt collections. The Board also held that the bad debts at issue was not allowable because the provider wrote them off prior to 120 days without documenting the basis for such write offs.

The Provider Reimbursement Manual states that a provider may write off bad debt prior to 120 days, but it must be able to document why the debt is worthless. This case should serve as a reminder that providers submitting cost reports with Medicare bad debts must adhere to their written collections policy and need to keep complete records of their collection efforts, particularly when writing off bad debts less than 120 days old.

PRRB Jurisdictional Decisions. The PRRB's recent jurisdictional decisions highlight the importance of complying with the procedural requirements for an appeal when attempting to obtain PRRB review of intermediary determinations. When a provider fails to meet the procedural and jurisdictional requirements, the Board will dismiss the appeal and the provider will not be able to seek review of the intermediary's determinations. This is where an experienced appeal representative can be valuable. PRRB appeals are generally due 180 days after receipt of the intermediary's determination, or where there is no final determination 12 months plus 180 days from the date the cost report was perfected. In June 2014, the Board dismissed an appeal that was filed on the 181st day.⁷ In July, the Board dismissed appeals that were filed on the 181st day and 191st day.⁸

Several PRRB jurisdictional decisions have addressed the "dissatisfaction" requirement for PRRB jurisdiction where the intermediary does not make a final determination.⁹ The Board dismissed the appeals because the providers failed to protest the reimbursement at issue on their cost reports, as required by 42 C.F.R. § 405.1835(a)(1). However, this rationale was recently rejected by both CMS and the United States District Court for the District of Columbia. On August 6, 2014, the D.C. District Court enjoined HHS and Medicare contractors from enforcing 42 C.F.R. § 405.1835(a)(1)'s PRRB jurisdictional requirement that a provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the item as a protested amount in its cost report.¹⁰ In the 2015 IPPS/LTCH PPS Final Rule, CMS made a "technical correction" to 42 C.F.R. § 405.1835 removing the "dissatisfaction" requirement for PRRB jurisdiction in cases where the intermediary did not issue a final determination.¹¹ This injunction and subsequent technical change to the regulation will make it easier for providers to appeal cost report items to the PRRB that were not claimed as protested amounts on cost reports, if the intermediary did not make a final determination by issuing a notice of program reimbursement ("NPR").

Claim Reopenings. A July decision from the United States District Court for the Eastern District of New York confirmed that providers may not seek review of an intermediary's decision to reopen a claim. In St. Francis Hospital v. Sebelius,¹² the provider brought constitutional claims to challenge the regulations that barred review of an intermediary's decision to reopen certain claims. The provider had 225 claims that were selected for review by a Recovery Audit Contractor ("RAC") and were all reopened by the intermediary for recoupment. The Court held there was no constitutional violation, the regulations prohibiting review of intermediary reopenings were not contrary to the Social Security Act, and the regulations were not arbitrary and capricious.

Statistical Sampling. In Chillicothe Chiropractic and Wellness Center v. Sebelius,¹³ a U.S. Magistrate Judge reviewed a provider's challenge to the Medicare Appeals Council's ("MAC") decision to uphold the use of statistical sampling utilized by a Medicare Program Safeguard Contractor ("PSC"). The PSC reviewed a sample of 100 claims, found an overpayment of only \$2,541.44 and extrapolated the sample finding to all of the Plaintiff's claims, resulting in a significantly larger overpayment of over \$90,000. The MAC had upheld the PSC's sampling methodology, but found that the overpayment should be recalculated at the lower limit of a one-sided, 90% confidence interval. The Magistrate Judge recommended that the District Court affirm the MAC's decision because the "MAC applied the appropriate legal standards in making its determination and that substantial evidence supports the determination." As a result, the provider's challenge to the PSC's statistical sampling methodology was unsuccessful at both the MAC and District Court, despite the provider's own forensic analysis alleging "widespread legal error" with the sampling methodology.

¹ Case No. 07-2069, PRRB Decision No. 2014-D5 (Apr. 9, 2014).

² Case No. 07-2006GC, PRRB Decision No. 2014-D6 (Apr. 10, 2014).

³ Maine Medical Center v. Sebelius, No. 2:13-cv-00118-JAW, 2014 WL 1234173 (D.Me. Mar. 25, 2014).

⁴ See Methodist Hospital, Inc. v. Wisconsin Physicians Service/BlueCross BlueShield Association, Case Nos. 04-1350, 05-1139, 06-1473, 06-1477, 04-1348, 05-1185, 06-1353, 06-1303 and 07-1344, PRRB Dec. No. 2014-D18 (Aug. 26, 2014) at 20; CHS 2004-2006 Medicare Bad Debt-Passive Collection CIRP Groups v. Intermediary, Nos. 08-0611GC, 08-0619GC, and 08-0621 GC, PRRB Decision No. 2014-D13 (July 1, 2014) at 15, 20-21.

⁵ St. John Health 2004-2005 Bad Debt Moratorium CIRP Group v. National Government Services/Wisconsin Physicians Service/Blue Cross Blue Shield Association, Case Nos. 09-1065GC and 09-2172G, PRRB Decision No. 2014-D19 (Aug. 27, 2014).

⁶ Case Nos. 07-0847 and 07-0306, PRRB Decision No. 2014-D11 (June 18, 2014).

⁷ Parkview Medical Center, PRRB Case No. 13-3738G (June 13, 2014).

⁸ Affinity Medical Center, PRRB Case No. 14-3458 (July 21, 2014); Presence Provena Mercy Center, PRRB Case No. 14-1781 (July 23, 2014).

⁹ See e.g., Patton Boggs 2011 Medicare Outlier Group, PRRB Case No. 13-3738GC (June 13, 2014).

¹⁰ Charleston Area Medicare Center, et al. v. Sebelius, No. 13-643 (D.D.C. Aug. 6, 2014).

¹¹ Final Rule, 79 Fed. Reg. 49854, 50199-200.

¹² No. 09 CV 1528(DRH), ___ F.Supp.2d ___, 2014 WL 3715117 (E.D.N.Y. July 23, 2014).

¹³ No. 2:12-cv-330, 2014 WL 1382478 (S.D.Ohio Apr. 8, 2014).

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