Recommendation 86-5

Medicare Appeals

(Adopted December 4, 1986)

The Medicare program, since 1965, provides health insurance for nearly all elderly and most disabled Americans. The program relies on hospitals, nursing homes and other health care institutions (under "Part A" of the program) and physicians and suppliers (under "Part B") to provide benefits to its beneficiaries.

This program, serving 30 million persons, has been administered since 1977 by the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS). Congress purposefully created a decentralized system, with implementation by localized carriers and intermediaries, primarily insurance companies. HCFA contracts with these organizations to administer the millions of claims made by beneficiaries each year and the resulting payments to providers. For Part A these organizations are known as "fiscal intermediaries" and for Part B they are referred to as "carriers." Additionally, statutorily-mandated peer review organizations (PROs), made up of physician-controlled organizations under contract with HCFA, have been given new responsibility to decide many disputes raised by beneficiaries and hospitals under Part A. To guide its contractors, HCFA issues health insurance manuals containing detailed instructions, though they normally are not published through notice-and-comment rulemaking.

HCFA also issues "national coverage decisions" on whether new medical technologies and procedures are covered by Medicare. These decisions are sometimes made after a recommendation is sought from the HHS Office of Health Technology Assessment (OHTA). Only when OHTA advice is sought does HCFA publish notice in the Federal Register. In most cases, affected manufacturers, providers, and beneficiaries have no notice or opportunity to file comments on proposed action, and neither HCFA nor OHTA has published its decision-making procedures or its criteria for making these decisions.

Rapidly rising program expenditures, especially inflation in hospital-care costs, led Congress to take a number of steps to control costs. In 1982, the PRO system was created and was delegated important responsibility to deny Medicare payment for inappropriate or unnecessary services and to sanction providers for improper practices. In the following two years Congress

froze physician charges for fifteen months and completely revamped the reimbursement system for hospitals by creating the "prospective payment system" under which Medicare pays hospitals a predetermined fixed price for each patient case (according to a classification system of some 470 Diagnosis Related Groupings or DRGs), regardless of the actual costs incurred in treating the patient. The prices are subject to annual updating and the classification system is to be reviewed annually. Congress created the advisory Prospective Payment Assessment Commission to participate in this process. Additionally, to mitigate fears that the prospective payment system might lead to unnecessary brief admissions or premature release of patients, Congress charged the PROs with the responsibility for monitoring hospital admissions and discharge practices. In the first years of this program, hospital admissions for the elderly declined for the first time since 1965, the average length of stay also declined and there was a greater utilization of outpatient services. Moreover, many hospitals have made record profits under the new system while reducing the rate of inflation in hospitals costs. There has also been a marked increase in physician (Part B) services, as patients have moved out of hospital and into outpatient care, and to greater reliance on home health services.

The Medicare appeals system is a patchwork with differing administrative and judicial review requirements for beneficiaries and providers and differing rules for Part A and Part B appeals.

Under Part A, most cases are beneficiary appeals primarily involving coverage determinations. Initial determinations are by PROs if hospital services are involved and by fiscal intermediaries for other Part A services. A reconsideration step is built in. After this "paper review," administrative review is then available by an administrative law judge in the Social Security Office of Hearings and Appeals if the amount in controversy exceeds $100 ($200 in hospital cases). The SSA Appeals Council may review and reverse the ALJ's decision on its own motion. Judicial review in the district court is available for the beneficiary if the amount in controversy is $1000 ($2000 in hospital cases).

Providers who have disputes concerning reimbursement under Part A (over $10,000) may bring appeals to the Provider Reimbursement Review Board (PRRB), a five-member board within HHS. (Appeals involving amounts between $1,000 and $10,000 are heard by fiscal intermediaries.) The Secretary may review PRRB decisions on his own motion and providers have a right to judicial review. The PRRB's effectiveness as an independent adjudicator of provider payments disputes has been called into question by provider groups who have raised concerns about its independence, jurisdiction, slowness and its procedures for handling group appeals. Moreover, the PRRB's role under the prospective payment system has been changing.

The Board does retain jurisdiction over appeals remaining under the old system and over some key issues concerning allowable costs, and availability of payments under the new system. But, HCFA rulings and regulations have constrained the PRRB's jurisdiction in prospective payment rate cases and provided that it may not order retrospective correction of errors in those rates. Moreover, some key provider appeals such as those involving errors in DRG assignment have been transferred to PROs. No further review is available in such cases.

Until passage of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509, there was no administrative and judicial review of Part B claims. However, under the new law, beneficiaries with disputed claims of over $500 (and physicians who have accepted assignment of such claims) have a right to a hearing before an administrative law judge, and to subsequent judicial review if the claim exceeds $1,000. Previously there was no judicial review and beneficiaries with Part B claims exceeding $100 were limited to a "fair hearing" before an officer selected by the carrier. (This procedure will continue for claims between $100 and $500 under the new legislation.)

The new legislation also made several other important changes in the laws affecting Medicare. The legislation:

–authorizes persons affiliated with providers to represent beneficiaries in Part A appeals as long as no financial liability is imposed in connection with the representation;

–requires that HCFA regulations regarding the Medicare program provide for a 60-day comment period;

–requires expanded notice procedures for Medicare patients concerning their hospital discharge rights;

–mandates various new requirements on PROs to review beneficiary complaints and to review the quality of care provided; and

–expands appeal rights in home health care cases involving so-called "technical denials" of benefits.

The Conference welcomes these changes. Indeed, at the time of their enactment, the Conference was actively considering recommendations concerning some of them. Other aspects of the process, however, also deserve modification or, at least, further study. We

therefore call upon HCFA to continue its efforts to improve the implementation of this important program by heeding the following specific suggestions.

Recommendation

I. Publication of Policies

A. The Health Care Financing Administration (HCFA) should keep up to date and provide reasonable access to all standards, guidelines and procedures used in making coverage and payment determinations under Part A and Part B of the Medicare program.

B. In promulgating interpretations of Medicare benefits likely to have substantial impact on the public, HCFA should adopt procedures that allow for public comment (either pre-promulgation or post-adoption). See ACUS Recommendation 76-5.[1]

C. HCFA by regulation (or Congress by legislation if necessary) should require fiscal intermediaries and carriers to publish and provide reasonable access to all insurance industry rules or other screening devices used in making coverage and payment determinations under Part A and Part B.

D. HHS should introduce more openness and regularity into the procedure for issuing "national coverage decisions" pertaining to new medical technologies and procedures, through: (1) Development of published decisional criteria; (2) providing for notice and inviting comments in such cases, both in HCFA's decisionmaking process and in the process by which the HHS Office of Health Technology Assessment supplies recommendations to HCFA; and (3) providing for internal administrative review or reconsideration of such decisions.

II. Administrative Appeal Procedures

A. HCFA should continue to develop and assess the adequacy and timing of notice to beneficiaries about coverage and payment decisions on medical benefits and appeal rights regarding these decisions.

B. Because of the increased caseload in Medicare appeals adjudication anticipated after the recent enactment of new appeal rights in Part B cases, HHS should consider whether

[1] ACUS Recommendation 76-5, “Interpretive Rules of General Applicability and Statements of General Policy,” 1 CFR 305.76-5.

modification of the existing adjudicatory system is necessary, including whether to establish a Medicare appeals division with its own administrative law judges and review procedure.

C. When resolving hospital rate appeals under the prospective payment system, the Provider Reimbursement Review Board should be authorized by regulation (or, if necessary, by legislation) to assume jurisdiction of an individual hospital's appeal in a manner that affords timely relief to successful appellants.

III. Suggestions for Further Study

HCFA should undertake or support additional research in the following areas:

A. An empirical study of the role, performance and procedures of:

(1) Fiscal intermediaries and carriers in making coverage and payment determinations under Part A and Part B;

(2) Peer review organizations in adjudicating Part A appeals by beneficiaries and by hospitals under the prospective payment system.

B. A comprehensive analysis of the current administrative arrangement by which hospital payment rates are updated under the prospective payment system (taking into account the need for fair ratemaking, timely resolution of disputes and budgetary controls), including an assessment of the Prospective Payment Assessment Commission in this process.

C. An examination of the future role and responsibilities of the Provider Reimbursement Review Board under the prospective payment system, including its jurisdiction, need for expedited review procedures for group appeals, qualifications for membership, adequacy of budget and administrative support, and the need for independence from the rest of the Department.

D. An examination of whether or not the implementation of the statutorily-mandated peer review program should be done to a greater extent through notice-and-comment rulemaking, rather than through reliance upon program instructions and contract provisions.

E. A study of HCFA's use of statistical sampling techniques to determine project overpayments to a provider for a given year, and whether the use of these techniques may effectively deny beneficiaries or providers the opportunity to challenge payment determinations based on actual claims experience.

F. A study of whether, in hospital rate appeals, HCFA should allow retroactive correction of erroneous calculations of a hospital's payment rate for affected prior years under the prospective payment system, and payment to hospitals accordingly.

G. A study of the process by which ALJ reversals of claim denials are implemented by intermediaries and providers, including the need for tighter accounting of payments to beneficiaries and reimbursements to providers.

H. An examination of the feasibility and utility of setting internal time guidelines for each stage of the Medicare appeals process, including reconsiderations, ALJ hearings and Appeals Council review.

Citations:

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