2016 – DME Policy Concerns

Medicare Audit and Appeal Process

Summary

Medical equipment providers throughout the country, who provide and service home medical equipment for Medicare beneficiaries, are experiencing excessive unreasonable denials of payment by CMS, via the contractors they have hired to analyze claims.

Chief Administrative Law Judge Nancy Griswold gave a testimony to the Senate Finance Committee in 2015 stating that there is **a total of 870,000 backlogged appeals**. There are only 65 judges nationwide that are able to review these appeals. Providers are facing an **average review timeline of three years to five years,** to be reimbursed for equipment that has already been purchased. Of great concern to providers is the propensity of CMS contractors to deny claims due to technical and/or clerical errors or lack of examination of the entire packet of documentation. After many months most of these denials are overturned by OMHA AMJs, allowing payment to occur. The process is time-consuming, frustrating and a burden on providers, beneficiaries and the system.

The American Hospital Association filed a suit in 2014 to try and clear a backlog of recovery audit contractor (RAC) appeals at the administrative law court level. There were at least 800,000 appeals at that level as of 2014. A lower federal court had dismissed the lawsuit due to lack of jurisdiction--essentially concluding because Congress was working on trying to procure more funding to review claims, it did not yet have the authority to act further. However, the case was recently reinstated by an appeals court.

In addition the severe delays and the suspension of due process in claims analysis are paralyzing the business community by tying up cash flow into recoupment proceedings that are eventually overturned. Meanwhile beneficiaries whose lives rely on wheelchairs, oxygen and other equipment for their independence wait long periods of time for their equipment as private contractors representing CMS exceedingly define their medical equipment needs as “medically unnecessary.”

LEGISLATIVE REMEDIES

- Suspend the CMS audit programs immediately to resume only when an effective timely appeal channel is available to all providers.
- Stop recoupments on current claim denials that are waiting an ALJ hearing.
- Refund recoupments that have already occurred if appeal was made after July 15, 2013; during the suspension of the appeal process.
- Prioritize medical necessity over technical issues that trigger denials in the first and second levels.
- Support reform legislation to require fairness in audit programs including a fast and effective independent appeal program that both protects the Medicare program, beneficiaries and medical equipment providers.

Current Legislation

- **S. 2368- “Audit and Appeals Fairness, Integrity, and Reforms in Medicare Act” by Sen. Hatch (R-UT)** Seeks to strengthen the current system with transparency, oversight and ensuring timely and high quality reviews.
- **H.R. 2437- Prior authorization bill by Rep. Marsha Blackburn (R-TN)** Seeks to develop and implement improved prior authorization processes for certain durable medical equipment, prosthetics, orthotics, and supplies.
- **Hospital Improvement Program by Rep. Kevin Brady (R-TX)** Establishes a new Recovery Audit contractor (RAC) reporting systems to provide information the number of RAC denials and those that are overturned at the third and fourth level appeals systems. It is imperative that “all providers” be included in this language.
- **H.R. 2568- “The Fair Medical Audits Act of 2015” by Rep. George Holding (R-NC)** Offers transparency and accuracy to the Medicare audit program. A crucial piece that is needed in this bill is **reinstating clinical inference** to allow Medical Review nurses and physicians to use their clinical knowledge to conclude the appropriate needs of the beneficiary.