Via Electronic Submission: DABStakeholders@hhs.gov

February 13, 2017

Constance B. Tobias, Chair, Departmental Appeals Board
Department of Health and Human Services
Departmental Appeals Board, MS6127
330 Independence Ave., S.W.
Washington, DC 20201

Re: Recommendations Implementing the Precedential Decision Authority

Dear Ms. Tobias:

We are responding to your request for comments for implementing the Departmental Appeals Board's (DAB's) authority to designate Medicare Appeals Council (MAC) decisions as precedential under the final rule on changes to the Medicare appeals process.[1] The American Association for Homecare (AAHomecare) represents suppliers, manufacturers and other stakeholders of durable medical equipment prosthetics orthotics and supplies (DMEPOS). DMEPOS products and services are central to ensuring Medicare meets the challenge of delivering safe, effective and affordable care to the chronically ill and the frail elderly.

AAHomecare welcomes the opportunity to submit these comments. Our members are disproportionately affected by the appeals backlog because of the benefit's unique design. We hope to highlight issues with broad general application to DMEPOS claims that once resolved could reduce the number of appeals suppliers submit. We discuss these in more detail below.

1. BACKGROUND

Under the final rule, precedential Council decisions will be binding on all Centers for Medicare & Medicaid Services (CMS) components, and on all Health and Human Services (HHS) and Social Security

[1] Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, 82 FR 4974-01 January 17 2017.

Administration components that adjudicate matters under the jurisdiction of the Centers for Medicare and Medicaid Services (CMS). The rationale for this new authority is that precedential decisions will eliminate repetitive appeals based on the same underlying rules or policies, reducing the appeals backlog. The DAB will publish notice of precedential designations in the Federal Register, and copies of precedential decisions will be posted on the DAB's website.

The final rule identified some of the information the DAB Chair may consider in determining whether to designate a decision as precedential. Generally, the DAB Chair would designate as precedential MAC decisions involving issues of wide applicability to improve the consistency of decisions moving forward. The Chair anticipates that these decisions will address recurring legal issues or recurring questions involving interpretations of CMS rules and policies. The DAB Chair may also consider whether a decision has general application to a broad number of cases, or whether a decision analyzes or interprets a legal issue of general public interest. The DAB Chair will publish decisions in the Federal Register before designating them as precedential.

Medicare pays for most DMEPOS either as rentals or recurrent purchases of supplies. The appeal of one rental claim affects the trajectory of all subsequent claims for the same item and their corresponding supplies and accessories because each claim arises from the one set of medical necessity facts. So although each monthly claim represents a new episode of service, the beneficiary's medical necessity and documentation supporting the claim are referenced at a single point in time, on or before the date of service for the initial claim.

For example, DME items like CPAPS and hospital beds typically have a 13-month rental period, after which a beneficiary receives title to the item. Oxygen equipment rents for 36 months then Medicare pays for medically necessary content refills for an additional 24 months before a new rental cycle begins. And because of the nature of equipment like ventilators and the patients that use them, Medicare pays to rent these items for as long as beneficiaries continue to need them.

If a contractor denies the initial claim for a CPAP item, the denial calls into question all subsequent claims for the item as well as claims for supplies and accessories for the item. Suppliers find themselves submitting and appealing claims for the 12 months left in the rental period, each of which winds its way through the levels of appeals independent from the others. So, resolving contractors' interpretation or misapplication of rules and Medicare policies is likely to significantly reduce the number of repetitive DMEPOS claims appeals.

2. Designating as precedential MAC decisions that clarify or reverse Medicare contractor policies or interpretive guidance that conflict with applicable rules, manual provisions or Medicare policies will reduce the number of repetitive appeals of DMEPOS claims which will, in turn, reduce the appeals backlog.

Frequent triggers for DMEPOS appeals are contractor policies and interpretative guidance that conflict with rules or other Medicare policies. Suppliers universally appeal claims contractors deny based on the misapplied rules and policies with overwhelming success. But because of the cyclical nature of DMEPOS claims, their success is at the expense of the appeals process that becomes clogged with all of the other rental or supply purchase claims for the same item.

CMS might eventually reverse or clarify the contractors' misapplied rules or interpretative guidance, but usually not before suppliers have filed thousands of appeals, including all the subsequent rental or purchase claims for an item, supply or accessories. Resolving these issues promptly by way of precedential decisions could significantly reduce the appeals backlog, eliminating the need for suppliers to file repetitive appeals.

The following are examples of recent scenarios that contribute to repetitive appeals.

- **Contractor policies imposing documentation requirements that do not follow applicable rules or Medicare policies trigger repetitive DMEPOS appeals that disproportionately contribute to the current backlog. For example, contractors have required suppliers to manually date stamp records like orders and beneficiary/physician encounters to prove when suppliers received them from referral sources even though applicable rules and Medicare policies do not require date stamps.**

Contractors have added requirements to medical record and other documentation that controlling rules, Medicare manual provisions or national or local coverage determinations (NCDs and LCDs, respectively) do not require. As one example, contractors have required suppliers to manually apply date stamps to records suppliers receive electronically from referral sources. Not only is this anachronistic requirement inconsistent with controlling rules and Medicare policies, it also undermines HHS' drive towards universal adoption of electronic health records (EHR).

Contractors' applied outdated date stamp polices to written orders prior to delivery (WOPDs), documentation of a beneficiary's face-to-face (F2F) encounter with a practitioner and orders for power mobility devices (PMDs) to prove the date suppliers received the documentation from a referral source. But although applicable rules require suppliers to have WOPDs and documented F2F encounters for certain DME and an NCD requires suppliers to have orders and medical necessity assessments before furnishing certain DME and PMDs, neither the rules nor the NCD requires suppliers to use a manual date stamp to prove when they received them. And Medicare manual provisions do not impose this requirement either.

Suppliers receive orders and medical record documentation electronically from referral sources, either from EHR systems or *via* electronic fax applications. These electronic records feed directly into the supplier's own electronic record systems. The media incorporate date and time stamp technologies to record the creation and electronic transmission of the information to suppliers. Suppliers' electronic record systems can integrate the referral sources' transmission without their having to print hard copies of the records.

To comply with manual date stamp requirements suppliers must first print a hard copy of the electronic record, apply a manual date stamp and then scan the record back into their electronic record systems. But, as we noted, Medicare rules and policies do not require manual date stamps on these records. Understandably, suppliers have appealed all claims denied for missing date stamps and have had a nearly 100% success rates on the appeals.

CMS recently reversed contractors' date stamp policies for WOPDs and F2F documentation. But by then, the policy had been in place over three years and suppliers had literally appealed these denied claims. And there are still potentally hundreds of these appeals pending hearings for ALJs to individually adjudicate each claim. CMS has yet to address contractor date stamp policies for PMD orders, but suppliers continue to appeal each initial claim and all the subsequent rental and supply/accessory claims for PMDs with missing date stamps with success.

- **Contractors continue to deny claims for power mobility devices because the doctor did not explicitly rule out a beneficiary's need for a cane, walker or manual wheelchair when the beneficiary is quadriplegic or a quadriparesis even though suppliers overwhelmingly succeed in reversing the denials on appeal.**

This is one example where the application of an NCD to the same set of facts across many appeals should always result in the same outcome. Many doctors simply do not see the point of explicitly documenting the beneficiary cannot use a cane, walker, or manual wheelchair when he cannot use his legs and arms. Suppliers succeed in reversing these claims on appeal. Eliminating these appeals would greatly reduce the appeals backlog.

- **An explicit precedential decision interpreting the LCD for prosthetics to allow the prosthetist documentation of the function level for prosthetic foot codes can be made by the treating physician AND/OR prosthetist will reduce unnecessary appeals for these devices**.

The LCD for the prosthetic foot codes explicitly states that either the physician or the prosthetist can document a beneficiary's function level that determines the type of device a beneficiary will use. When contractors deny claims for lack of physician documentation, suppliers win on appeal.

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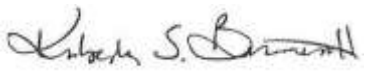
We hope you find these comments useful as you begin to implement the DAB Chair's authority to designate MAC counsel decisions precedential. AAHomecare welcomes the opportunity to have further discussions on issues that directly impact the DMEPOS industry. Please feel free to contact me if I can be of any assistance.

Sincerely,



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