

MEMORANDUM

Date: January 17, 2017

Subject: Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures (HHS-2015-49)

OVERVIEW

On January 13, 2017, The Department of Health and Human Services (HHS) published the final rule [“Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures.”](#) This final rule would revise the procedures that HHS would follow at the Administrative Law Judge (ALJ) level for appeals of payment and coverage determinations for items and services furnished to Medicare beneficiaries. In addition, this proposed rule would revise procedures that HHS would follow at CMS and the Medicare Appeals Council (Council) levels of appeal for certain matters affecting the ALJ level.

The regulations will go into effect on March 20, 2017.

The following is a section by section summary of what was in the proposed rule followed by an *explanation of the final rule in bold-italic-red text.*

BACKGROUND

From FY2009 to FY2014, ALJ workload increased by 1,222 percent. The increasing number of appeal requests have caused long delays for appellants to obtain hearings and decisions. Despite significant gains in OMHA ALJ productivity (in FY 2014, each OMHA ALJ issued, on average, a record 1,048 decisions and an additional 456 dismissals), and CMS and OMHA initiatives to address the increasing number of appeals, the number of requests for an ALJ hearing and requests for reviews of QIC and IRE dismissals continue to exceed OMHA’s capacity to adjudicate the requests. As of April 30, 2016, OMHA had over 750,000 pending appeals, while OMHA’s adjudication capacity was 77,000 appeals per year, with an additional adjudication capacity of 15,000 appeals per year expected by the end of Fiscal Year 2016.

PROPOSAL

Precedential Final Decisions of the Secretary

This proposal introduces precedential authority to the Medicare claim and entitlement appeals process. Proposal would grant authority to the Chair of the Departmental Appeals Board (DAB) to designate a final decision of the Secretary issued by the Council as precedential. The intention of this proposal is to provide appellants with a consistent body of final decisions of the Secretary upon which they could determine whether to seek appeals. It would also assist appeal adjudicators at all levels of appeal by providing clear direction on repetitive legal and policy questions, and in limited circumstances, factual questions. In the limited circumstances in which a precedential decision would apply to a factual

question, the decision would be binding where the relevant facts are the same and evidence is presented that the underlying factual circumstances have not changed since the Council issued the precedential final decision.

To help ensure appellants and other stakeholders are aware of decisions that are precedential, CMS is proposing to require notice of precedential decisions to be published in the Federal Register, and the decisions themselves would be made available to the public. Designated precedents would be posted on an accessible website maintained by HHS. Decisions of the Council would bind all lower-level decision-makers from the date that the decisions are posted on the HHS website.

Make these precedential decisions binding on all CMS components, on all HHS components that adjudicate matters under the jurisdiction of CMS, and on Social Security Administration (SSA) to the extent that SSA components adjudicate matters under the jurisdiction of CMS, in the same manner as CMS Rulings. CMS is not proposing to change the non-precedential status and non-binding effect on future initial determinations (and equivalent determinations) or claim appeals of any determinations or decisions except as to Council decisions designated as precedential by the DAB Chair.

The Council's legal analysis and interpretation of an authority or provision that is binding or owed substantial deference would be binding in future determinations and appeals in which the same authority or provision is applied and is still in effect. However, if CMS revises the authority or provision that is the subject of a precedential decision, the Council's legal analysis and interpretation would not be binding on claims or other disputes to which the revised authority or provision applies. For example, if a Council decision designated as precedential by the DAB Chair interprets a CMS manual instruction, that interpretation would be binding on pending and future appeals and initial determinations to which that manual instruction applies. However, CMS would be free to follow its normal internal process to revise the manual instruction at issue. Once the revised instruction is issued through the CMS process, the revised instruction would apply to making initial determinations on all claims thereafter. This would help ensure that CMS continues to have the ultimate authority to administer the Medicare program and promulgate regulations, and issue sub-regulatory guidance and policies on Medicare coverage and payment.

If the decision is designated as precedential by the DAB Chair, this proposal would also make the Council's findings of fact binding in future determinations and appeals that involve the same parties and evidence. However, CMS notes that many claim appeals turn on evidence of a beneficiary's condition or care at the time discrete items or services are furnished, and therefore this proposal is unlikely to apply to findings of fact in these appeals. In addition, CMS is proposing to add precedential decisions designated by the Chair of the DAB as an authority that is binding on the QIC.

FINAL RULE: HHS will add language clarifying that when, "determining which decisions should be designated as precedential, the DAB Chair may take into consideration "decisions that address, resolve, or clarify recurring legal issues, rules or policies, or that may have broad application or impact, or involve issues of public interest." The rest of this section has been finalized without modifications.

Attorney Adjudicators

To enable OMHA to manage requests for an ALJ hearing and requests for reviews of QIC and IRE dismissals in a more timely manner and increase service to appellants, while preserving access to a hearing before an ALJ in accordance with the statutes, CMS is proposing to provide authority that would allow attorney adjudicators to issue decisions when a decision can be issued without an ALJ conducting a hearing under the regulations, dismissals when an appellant withdraws his or her request for an ALJ hearing, and remands for information that can only be provided by CMS or its contractors or at the direction of the Council; as well as to conduct reviews of QIC and IRE dismissals. CMS is proposing to revise the rules so that decisions and dismissals issued by attorney adjudicators may be reopened and/or appealed in the same manner as equivalent decisions and dismissals issued by ALJs. Allowing attorney adjudicators to issue decisions, dismissals, and remands as described above, and to conduct reviews of QIC and IRE dismissals would expand the pool of OMHA adjudicators and allow ALJs to focus on cases going to a hearing, while still providing appellants with quality reviews and decisions, dismissals, and remands. In addition, the rights associated with an appeal adjudicated by an ALJ would extend to any appeal adjudicated by an attorney adjudicator, including any applicable adjudication time frame, escalation option, and/or right of appeal to the Council.

In addition, CMS notes that even if an attorney adjudicator was assigned to adjudicate a request for an ALJ hearing, that hearing request still could be reassigned to an ALJ for an oral hearing if the attorney adjudicator determined that a hearing could be necessary to render a decision. CMS also notes that parties to a decision that is issued without an ALJ conducting an oral hearing continue to have a right to a hearing and a right to examine the evidence on which the decision is based and may pursue that right by requesting a review of the decision by the Council, which can remand the case for an ALJ to conduct a hearing and issue a new decision.

CMS proposed to define an “attorney adjudicator” as a licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance. In addition, CMS is proposing to indicate that the attorney adjudicator is authorized to take the actions provided for in subpart I on requests for ALJ hearing and requests for reviews of QIC dismissals. These proposals would provide the public with an understanding of the attorney adjudicator’s qualifications and scope of authority, and CMS also notes that attorney adjudicators would receive the same training as OMHA ALJs.

FINAL RULE: The proposals are finalized without modifications.

Application of 405 Rules to Other Parts

Current regulation references part 405 when there are limitations to a regulation. For example, 422.562(d) states that unless subpart M regarding grievances, organization determinations and appeals under the Medicare Advantage program provides otherwise, the regulations found in part 405 apply under subpart M to the extent appropriate.

These general references to part 405 are often helpful in filling in gaps in procedural rules when there is no rule on point in the respective part. However, there has been confusion on the application of part 405 rules when a part 405 rule implements a specific statutory provision that is not in the authorizing

statute for the referring subpart and HHS has not adopted a similar policy for the referring subpart in its discretion to administer the Medicare Advantage, QIO, and cost plan appeals programs. To clarify the application of the part 405 rules, CMS is proposing revisions to parts 422 and 478. This proposal would provide that the part 405 rules do not apply when the part 405 rule implements a statutory provision that is not also applicable to section 1852 of the Act. Similarly, this proposal would provide that the part 405 rules do not apply when the part 405 rule implements a statutory provision that is not also applicable to section 1155 of the Act. In addition, this proposal removes language that equates an initial determination and reconsidered determination made by a Quality Improvement Organization to contractor initial determinations and reconsidered determinations under part 405 because that language has caused confusion with provisions that are specific to part 405 and QIC reconsiderations, and it is not necessary to apply the remaining part 405, subpart I procedural rules in part 478, subpart B proceedings. In addition to clarifying the application of part 405 rules to other parts, these revisions would help ensure that statutory provisions that are specific to certain Medicare appeals are not applied to other appeals without HHS first determining, through rulemaking, whether it would be appropriate to apply a provision and how best to tailor aligning policies for those other appeals.

FINAL RULE: HHS will add clarifying language in 422.562(d), 422.608, and 478.40(c) on part 405 provisions that implement provisions of section 1869 of the Act that are not also applicable to sections 1852 or 1155 of the Act, and that HHS does not believe apply to part 422, subpart M and part 478, subpart B adjudications.

OMHA References

When the 2005 Interim Final Rule was published in March 2005, implementing the part 405, subpart I rules, OMHA was not yet in operation. Further, processes and procedures were being established under the part 405 subpart I rules, with new CMS contractors and the newly transitioned ALJ hearing function. Since that time, OMHA and CMS and its contractors have developed operating arrangements to help ensure appeals flow between CMS contractors and OMHA, and that appeal instructions for appellants provide clear direction on how and where to file requests for hearings and reviews. However, many of the current rules for the ALJ hearing program that OMHA administers reflect the transition that was occurring at the time of the 2005 Interim Final Rule, and OMHA is not mentioned in the regulation text.

To provide clarity to the public on the role of OMHA in administering the ALJ hearing program, and to clearly identify where requests and other filings should be directed, we are proposing to define OMHA as the Office of Medicare Hearings and Appeals within the U.S. Department of Health and Human Services, which administers the ALJ hearing process. We are also proposing to amend rules to reference OMHA or an OMHA office, in place of current references to an unspecified entity, ALJs, and ALJ hearing offices, when a reference to OMHA or an OMHA office provides a clearer explanation of a topic.

FINAL RULE: The proposals are finalized without modifications.

Medicare Appeals Council References

The Council is currently referred to as the “MAC” throughout current part 405, subpart I; part 422, subpart M; and part 423, subparts M and U. This reference has caused confusion in recent years with



the transition from Fiscal Intermediaries and Carriers, to Medicare administrative contractors—for which the acronym “MAC” is also commonly used—to process claims and make initial determinations and redeterminations in the Medicare Part A and Part B programs. In addition, current §§422.618 and 422.619 reference the Medicare Appeals Council but use “Board” as the shortened reference, and part 478, subpart B, references the DAB as the reviewing entity for appeals of ALJ decisions and dismissals but the Council is the entity that conducts reviews of ALJ decisions and dismissals, and issues final decisions of the Secretary for Medicare appeals under part 478, subpart B.

To address potential confusion with references to Medicare administrative contractors and align references to the Council as the reviewing entity for appeals of ALJ decisions and dismissals we are proposing to amend the following rules to replace “MAC” or “Board” with “Council” in throughout the Act.

In addition, to align references to the Council as the reviewing entity for appeals of ALJ decisions and dismissals in part 478, subpart B, we are proposing to amend §§478.46 and 478.48 to replace “Departmental Appeals Board” and “DAB,” with “Medicare Appeals Council” and “Council”.

If you choose to comment on this portion of the proposal, CMS requests commenters to include the caption “Medicare Appeals Council references” at the beginning of your comment.

FINAL RULE: The proposals are finalized without modifications.