National Home Infusion Association
Providing solutions for the infusion therapy community

December 5, 2014

Nancy J. Griswold
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
Department of Health and Human Services
Attention: OMHA-1401-NC
1700 N. Moore Street
Suite 1800
Arlington, VA 22209

Dear Judge Griswold:

The National Home Infusion Association (NHIA) appreciates the opportunity to offer recommendations to OMHA regarding how it can effectively address the substantial increase in the number of requests for hearings being filed with OMHA as well as the backlog of pending cases. NHIA is a national membership association for clinicians, managers and organizations providing infusion therapy services for patients in home care and outpatient settings. Our members include independent local and regional home infusion pharmacies; national home infusion provider organizations; and hospital-based home infusion organizations.

NHIA believes that OMHA can directly impact the number of requests for hearings and the current backlog of pending cases by (1) expanding the use of the alternative dispute resolution process utilized in the Settlement Conference Facilitation Pilot;(2) requiring providers and CMS to submit communication logs that document good faith efforts to resolve claims before proceeding to the next level of the appeals process; and (3) establishing a separate, expedited review process for appeals regarding technical denials of claims.

In addition, NHIA believes that OMHA should work with CMS to address flaws with the underlying medical review process that have contributed to the significant increase in the number of appeals. For instance, OMHA should encourage CMS to implement a required 30-day waiting period before the Medicare Administrative Contractors (MACs) are permitted to send demand letters on non-RA claims. As another example, OMHA should urge CMS to implement an overall additional documentation request (ADR) limit for each provider that applies to both the RAs and the MACs and require the RAs and the MACs to tie their ADR limits and demands for information, respectively, to providers' denial rates. Additionally, CMS should reduce the financial burdens imposed on providers by recouping disputed funds from a provider that has appealed a claim determination to the ALJ level only <u>after</u> the provider receives an ALJ determination.

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1. Recommendations Related to the OMHA Level of Appeal

NHIA supports the Settlement Conference Facilitation Pilot (SCF) as a well-intended effort to address the current backlog of Medicare appeals. We also commend OMHA for hosting two Medicare Appellant Forums and for soliciting feedback from stakeholders on how to improve the appeals process. We believe that OMHA can adopt several policies to expedite its reviews and reduce the backlog of pending cases.

A. OMHA should allow all providers to use the alternative dispute resolution process utilized in the Settlement Conference Facilitation Pilot, and should require that all providers who submit requests for hearings beginning in 2015 have the option of participating in the process if their claims exceed $10,000.

NHIA believes that the alternative dispute resolution process being used in the SCF Pilot can effectively reduce the backlog and alleviate OMHA's current workload. We understand that OMHA initially limited participation the SCF Pilot to providers who filed a request for a hearing in 2013 and who were not assigned to an ALJ in order to avoid being overwhelmed by requests to participate in the Pilot. However, we believe that the narrow eligibility requirements inadvertently curtailed the potential impact of the program.

NHIA believes that all providers should have the opportunity to participate in the alternative dispute resolution process utilized in the SCF Pilot regardless of when they file a request for a hearing. Many providers who filed requests for hearings before 2013 and in 2014 would welcome the opportunity to meet with CMS and a facilitator to resolve the disputed claims in an expedited manner. In addition, we believe that beginning in 2015, all requests for hearings for claims that exceed $10,000 should automatically include a request to participate in this alternative dispute resolution process. OMHA should process these requests in the order that they are received, and providers should be required to participate in the first available dispute resolution process (i.e., the alternative dispute resolution process or an ALJ hearing). If the alternative dispute resolution process becomes available before an ALJ hearing, and the provider participates in the process but does not agree with the outcome, they should remain in the queue, based on the date their initial request was filed, to be assigned to an ALJ. NHIA believes that expanding the alternative dispute resolution process could expedite the resolution of disputed claims and alleviate the ALJs' workload.

B. OMHA should require providers and CMS to engage in good faith efforts to resolve the claims before proceeding to the next level of the appeals process, and to submit communication logs that details discussions related to this effort.

NHIA does not believe that the RACs and MACs effectively communicate with providers when they encounter deficient claims, thereby contributing to the significant increase in requests for hearings and the resulting backlog at OMHA. In addition, this lack of communication may result in claims being denied for technical reasons, such as requests for documentation that has already been provided, orders lacking a physician signature that have been electronically signed, applying request for refill (RFR) documentation requirements to supply kits that are exempt

from RFR, to name a few. Providers attempt to contact the RACs or MACs regarding these denials, but are often told to proceed to the next level of appeal.

NHIA believes that a number of appeals at the OMHA level of review could be avoided if the RACs and MACs are required to communicate with providers regarding deficiencies, and if providers have the opportunity to correct claims with technical flaws. We urge OMHA to require the parties to engage in good faith discussions to resolve disputed claims prior to escalating the claims to the next level of review. OMHA should require all parties to a dispute to submit communication logs that describe these discussions between the MACs or RACs and the providers. NHIA believes that the contractors and providers may be encouraged to resolve disputed claims if they have to record their communications. Importantly, these logs can be used by the ALJs to determine whether each party engaged in good faith efforts to resolve the disputed claims.

C. OMHA should establish a separate, expedited review process for appeals based on technical issues.

As mentioned above, claims are often denied due to technical reasons. We believe that OMHA should consider establishing an expedited review process for appeals that are purely technical in nature. This review process could be mostly automated, and should allow providers to correct inadvertent technical errors without having to escalate the claims to the next level of review.

2. Recommendations Related to the Medical Review Process that Triggered the Increase in Workload at OMHA.

NHIA has several suggestions to reform the underlying medical review process that has contributed to the significant increase in the number of appeals over the past decade. We believe that OMHA should encourage CMS to become a partner in addressing the systemic failures that have contributed to the significant backlog at the ALJ level of appeal by adopting the policies set forth below.

A. OMHA should urge CMS to implement 30-day delays for the RAs and the MACs to encourage discussions between the contractors and the providers who filed the claims.

NHIA believes that CMS will be including in its future RA contracts a requirement that the RAs wait at least 30 days before sending claims to the MACs. Likewise, we believe OMHA should encourage CMS to include a similar requirement in its contracts with the MACs, so that the MACs delay sending demand letters on non-RA claims for at least 30 days, thereby giving providers an opportunity to correct the record without having to file a formal appeal. These required waiting periods should be coupled with a requirement that the contractors engage in meaningful discussions with the providers about concerns related to the claims. The delays and discussions would give providers the opportunity to identify and address certain issues in claims without going through the formality of an appeal. The providers and contractors could effectively resolve "technical denials" in a timely fashion without burdening the appeals process, as long as the 30-day waiting period includes a genuine dialogue on the issues with a claim.

B. OMHA should encourage CMS to implement an overall additional documentation request (ADR) limit for each provider that applies to both the RAs and the MACs and require the RAs and the MACs to tie their ADR limits and demands for information, respectively, to providers' denial rates.

NHIA agrees with CMS' growing recognition that not all claims need be treated alike, and believes that the contractors need to prioritize their attention and limited resources. Thus, we believe that CMS should establish an ADR limit for each provider that applies to the RAs and the MACs. In addition to this lower limit, CMS should require the RAs to implement policies that would apply lower ADR burdens to providers with lower denial rates. Likewise, CMS should require the MACs to triage demands for information from providers based on providers' denial rates. We believe that these limits and processes will enable CMS to more effectively utilize its limited resources.

C. OMHA should encourage CMS to recoup disputed funds from a provider that has appealed a claim determination to the ALJ level only after the provider has received an ALJ determination.

Providers should not be penalized for the backlog at OMHA. Nonetheless, due to the backlog and the current practice of recouping funds at a lower of level of appeal, providers are shouldering a considerable financial burden. Specifically, these providers have to wait for a favorable judgment at the OMHA level of review in order to retain payment for their services, which is currently years after they file the request for a hearing. Thus, we suggest that CMS change its practice to recoup disputed funds from providers who have filed an appeal with OMHA until after the ALJ has issued its decision.

The fact that ALJ adjudication timeframes are now in excess of 500 days is perpetuating the number of appeals being filled. Long term patients, such as those being treated with parenteral nutrition or inotropic therapy, may be on service for many years. If there is a question about these long term patients qualifying for coverage, claims will continue to be submitted in order to meet timely filing deadlines. These claims are often denied for the same reason as the initial claims awaiting an ALJ hearing, which is adding to the backlog.

Please feel free to have your staff contact Bill Noyes, NHIA Vice President of Health Information Policy, at (603) 736-0308 or bill.noyes@nhia.org should you want to discuss our comments further. Thank you for your consideration of NHIA's comments.

Sincerely,

Russell Bodoff
President & CEO
National Home Infusion Association