New Medicare Appeals Process Raises Concerns

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

A new process for appealing Medicare coverage denials is raising concerns among some advocates for senior citizens.

"We're concerned about the ability of beneficiaries to get a fair and favorable hearing," said Vicki Gottlich, senior policy attorney at the Center for Medicare Advocacy, a Mansfield, Conn.–based group that helps beneficiaries with the appeals process. "Our organization and other organizations that do this kind of work have a very high success rate [for Medicare appeals] and we're concerned that the rate is going to go down."

That could mean collection snags for physicians, she added. For example, if the physician accepts assignment for Medicare, Medicare denies coverage for a claim, and the denial is unsuccessfully appealed by the patient, "the doctor will then have to go collect from the patient. They don't want to do that."

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Under the new process, which began on July 1, beneficiaries and providers whose claims are denied will be asked to appeal their claims to an administrative law judge (ALJ) via teleconference. Previously, these appeals were made in person.

"Older people and people with disabilities will have problems" with teleconferences, especially if their vision or hearing is impaired, Ms. Gottlich said. And if they ask for an in-person hearing instead, beneficiaries will waive their right to a timely decision if that request is granted. The new process also specifies that there will be three "regions" for hearing cases in person, rather than beneficiaries being allowed to have hearings in their home states.

Department of Health and Human Services spokesman Bill Hall said there are logistical reasons for waiving the right to speedy resolution in the case of an in-person hearing.

"We have to schedule everyone, allow time for them to travel, and set up a facility for the hearing," he said. "So logistics must come in play. That doesn't mean we'll take a year to do it."

Ms. Gottlich noted that the changes were made in the first place in part because members of Congress were dissatisfied with how long it was taking for beneficiaries to make their way through the appeals process.

"The changes are supposed to protect beneficiaries," but the system needs better funding to make sure everyone gets their chance to be heard in a timely way, she said. "There are some cases where teleconferencing could work, but for an individual beneficiary who's gone through the whole inhuman system and wants to see a real person, the system doesn't really work."

Another change in the process places administrative law judges under the jurisdiction of HHS, rather than the Social Security Administration. Further, judges are instructed to place more weight on Medicare regulations than they were before. "The [law] says the administrative law judge is supposed to be independent of [the Centers for Medicare and Medicaid Services], but now they are supposed to give deference to their rules," Ms. Gottlich said.

Mr. Hall said that his agency "has gone to great lengths to be sure this is a fair process." Questions about how well the new system will work "are virtually impossible to answer because we haven't even heard the first case yet. I think it's a lot more fair to ask these questions a year from now."

The Medical Group Management Association, which represents medical practice managers, is one group that is very interested in how the appeals process plays out. "We have concerns about how effective arbitration or review will be through a distance," said Jennifer Miller, external relations liaison at MGMA's Washington office. "How effective can someone be to advocate their position over teleconference? When the rubber hits the road and we start seeing more [cases], we'll have a better feel for it."

Ms. Miller added that MGMA supports having the judges hired by HHS rather than the Social Security Administration. "Before now, someone dealing with disability issues would be trying to adjudicate what may be their third case of this type out of 300 cases, so they may not be as familiar with it," she said. "Now there will be a specialized group of magistrates—it's going to be a new breed of ALJ."

MGMA is not concerned that being hired by HHS will bias the judges too much, she added. "That is a concern many still share; however, ALJs historically have enjoyed a great deal of flexibility, and that's the genius behind the review process," Ms. Miller said.

Several senators expressed concern about changes to the appeals process. A bill, the Justice for Medicare Beneficiaries Act, sponsored by Sens. Christopher Dodd (D-Conn.), Edward M. Kennedy (D-Mass.), John Kerry (D-Mass.), and Jeff Bingaman (D-N.M.) was introduced earlier this summer and would reverse many of the changes.

For instance, the bill says that judges "shall not be required to give substantial deference to local coverage determination, local medical review policies, or Centers for Medicare and Medicaid Services program guidance." The measure also calls for appeal hearings to be in-person "unless such individual requests that the hearing be conducted using tele- or video conference technologies." The bill was referred to the Senate Finance Committee. ■

POLICY & PRACTICE

Bill Would Repeal SGR

Physician groups are hailing the fact that a forthcoming bill from Rep. Nancy Johnson (R-Conn.), chair of the House Ways and Means Subcommittee on Health, would repeal Medicare's sustainable growth rate and base future updates for physician payments on the Medicare Economic Index. At a recent hearing, Mark McClellan, M.D., administrator for the federal Centers for Medicare and Medcaid Services, informed Rep. Johnson that such a measure could come at a high cost: specifically, that MEI-based increases would be $183 billion over 10 years. Her bill seeks to establish a performance measurement and reporting system. C. Anderson Hedberg, M.D., president of the American College of Physicians, testified that Rep. Johnson's bill should provide funding to support quality improvement, so that all physicians would receive a positive update linked to inflation with the opportunity to receive additional reimbursement for participating in performance measurement.

No More Caps in Wisconsin

The Wisconsin Supreme Court's decision to remove a 30-year-old cap on noneconomic damages in malpractice cases opens the door for a medical liability crisis, the American Medical Association said. The court held that the cap, currently set at $445,775, was "unconstitutional beyond a reasonable doubt." The decision will endanger Wisconsin's stable health care environment, AMA Trustee Cyril M. Hetsko, M.D., said in a statement. Wisconsin medical groups are concerned that the decision "will force a wave of doctors to retire early or stop performing high-risk procedures," such as delivering babies in rural areas, said Susan Turney, M.D., chief executive officer of the Wisconsin Medical Society.

Air Travel With Medical Oxygen

Starting this month, the Federal Aviation Administration is allowing people with respiratory disease to bring their own portable oxygen concentrators on board commercial flights. Although pleased with the ruling, the American Thoracic Society's President Peter D. Wagner, M.D., expressed concerns that the rule allows but does not require airlines to let passengers use portable oxygen concentrators. The Department of Transportation should use its regulatory authority under the Air Carrier Access Act to ensure portable oxygen concentrators can be used on all commercial passenger planes, he said.

Information Technology Deficit

Most Medicare fee-for-service outpatient visits in 2001 were to physicians with limited information technology support for patient care, the Center for Studying Health System Change (HSC) reported. Linking Medicare claims data to HSC's national physician survey, researchers found that 57% Medicare outpatient visits were to physicians in practices that used IT for no more than one of the following five clinical functions: obtaining treatment guidelines, exchanging clinical data with other physicians, accessing patient notes, generating preventive treatment reminders for the physician's use, and writing prescriptions. Although half of those visits were to physicians using IT to obtain treatment guidelines, the proportion of visits to physicians in practices with IT support for other patient care functions was much lower, falling to 9% for electronic prescribing. Access to "wired" practices was low for all beneficiaries, but HSC found few differences in access between sicker and healthier beneficiaries.

Ethics Problems at the NIH

More than 40 employees at the National Institutes of Health were found to have violated the agency's conflict of interest rules, according to the House Energy and Commerce Committee. Last year, the Committee identified a sample of 81 NIH scientists who were hired by drug companies between 1999 and 2004 but whose activities were not listed in NIH reports to the Committee. An NIH review, which was reported to the Energy and Commerce Committee, cleared 37 of the scientists but found that 44 had violated one or more of the NIH rules including reporting income on financial disclosure forms, taking personal leave to do private work, and seeking prior approval for consulting arrangements. Of the 44 scientists, 36 are still employed at NIH and have been referred for possible disciplinary action, and 9 of the 36 are facing investigation of possible criminal violations by the Health and Human Services Office of Inspector General. After months of congressional hearings on possible financial conflicts of interest by NIH employees, NIH issued an interim final regulation earlier this year that tightens restrictions on outside consulting arrangements with industry.

Soft Drink Wars

The Center for Science in the Public Interest is targeting the public's consumption of soft drinks, something the group labels as "liquid poison." Carbonated soft drinks are the single biggest source of calories in the American diet—and frequent consumption is a likely contributor to overweight and obesity, the group stated. In a petition, CSPI called on the Food and Drug Administration to require a series of rotating health notices on containers of all nondiet soft drinks (carbonated and noncarbonated) that contain more than 13 g of refined sugars per 12 ounces. In a statement, Susan Neely, president and chief executive officer of the American Beverage Association, said the CSPI's proposed warning labels on soft drinks patronized consumers and lacked common sense. "Even skim milk and thousands of other food products could potentially fit into a CSPI labeling scheme because of the sugars contained in those products," she said.

—Jennifer Silverman