December 5, 2014

Nancy J. Griswold, Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
Department of Health and Human Services
1700 N. Moore St. Suite 1800
Arlington, VA 22209

Via electronic delivery to: http://www.regulations.gov

Re: Request for Information OMHA-1401-NC "Medicare Program; Administrative Law Judge Hearing Program for Medicare Claims Appeals"

Dear Chief Judge Griswold,

The following comments are submitted on behalf of the National Coalition for Assistive and Rehab Technology (NCART) in regards to the Office of Medicare Hearings and Appeals' (OMHA) request for information OMHA-1401-NC "Medicare Program; Administrative Law Judge Hearing Program for Medicare Claims Appeals".

NCART is a national association of suppliers and manufacturers focused on ensuring individuals with significant disabilities and chronic medical conditions have adequate access to Complex Rehab Technology (CRT) products and services. CRT includes medically necessary and individually configured manual wheelchairs, power wheelchairs, seating systems, and other adaptive equipment such as standing devices and gait trainers.

Individuals who rely on CRT, both children and adults, have a diagnosis such as cerebral palsy, spinal cord injury, traumatic brain injury, ALS, multiple sclerosis, cerebral palsy, or muscular dystrophy. This specialized equipment requires evaluation, configuration, fitting, adjustment, and programming to meet the individual's medical needs and maximize the person's function and independence.

NCART works with consumers, clinicians, and physicians to collaborate with policy makers in establishing and protecting coverage, coding, and payment policies to ensure adequate access to CRT. Our members have over 300 CRT supplier locations across the country.

Background

The growing issues related to excessive denials and audits along with the ALJ Hearing backlogs are suffocating dedicated Medicare CRT suppliers. These companies are providing quality specialized

equipment and services to the most vulnerable of the Medicare beneficiary population but cannot survive the ever increasing financial pressures resulting from large number of inappropriate denials that are eventually reversed at the ALJ level. This was an issue in the past, but has become an even more critical issue given the massive ALJ backlog and resultant delays in hearings.

A recent survey of Medicare CRT suppliers indicates ALJ appeals of CRT denials result in reversal decisions over 90% of the time, well above the national average. As a result, CRT suppliers have millions of dollars on hold and are waiting years for payments of legitimate Medicare claims.

This is a national problem, creating hardships for CRT beneficiaries and suppliers across the country:

- Beneficiaries in need of CRT suffer from some of the most debilitating health conditions including ALS, muscular dystrophy, spinal cord injury, and traumatic brain injury. Denial of access to CRT for people with complex disabilities harms them and increases Medicare's costs.
- Due to their significant disabilities, beneficiaries require adjustments, repairs and additional components for their CRT equipment throughout its useful life. These needed services and additions will not be covered by Medicare while the original equipment remains denied.
- Medicare CRT suppliers are being forced to wait for payment for up to 3 years after the equipment and services have been delivered. This creates a major barrier and disincentive for companies to provide this specialized equipment and services to CRT beneficiaries.
- Many CRT companies will go out of business due to the very thin operating profits in this sector that do not provide an ability to wait years for payment of this high cost equipment.

Part of the solution to these problems is passage of related federal legislation. H.R. 5083- "Audit Improvement and Reform Act" (aka the AIR Act) has been introduced by Reps. Renee Ellmers (R-NC) and John Barrow (D-GA). The bill aims to address key problems with Medicare's unchecked audit system by boosting transparency within the program, providing better education and outreach, and rewarding suppliers that have low error rates on audited claims.

Specific Recommendations

We appreciate the opportunity to provide comments and recommendations to address the problems at hand. In addition to the recommendations included in the Congressional legislation mentioned above, we offer the following under two headings:

Related to CMS processes and policies:

1.) Conduct a thorough examination of the reasons for denials at the Medicare Administrative Contractor (MAC) level and identify where improvements can be made (policy clarification or modification, internal/external education, etc.).
2.) For "technical denials" (missing/ineligible signatures, conflicting dates, other reasons not relating to matters of law) make changes in the appeals process for these to be addressed and resolved through Level 1 and Level 2 reviews. This may be the most important short-term change that would have an immediate impact on decreasing the number of claims that are inappropriately going on to an ALJ Hearing.
3.) Reinstate the ability to use "clinical inference" at Level 1 and Level 2 reviews.

4.) Expand the current Prior Authorization Program for Power Mobility Devices (PMDs) to all PMD codes and to all areas of the country. This is widely supported by the CRT and HME industry.
5.) Allow for an exemption from the "timely filing requirement" for DME rental claims.
6.) Reinstate Level 3 reviews for individual consideration for beneficiaries who have a medical need for a technology but who do not have a diagnosis that is covered by the corresponding LCD.
7.) Hold physicians accountable for maintaining adequate medical records that meet CMS requirements.
8.) Hold DME MACs and other contractors accountable for improper denials that are eventually overturned. Right now there is no incentive for them to ensure all denials are proper. There is no penalty for bad denials that are contributing to the excessive workload and back log.

Related to OMHA processes and policies:

1.) Track reasons for denials in an effort to identify inadequacies in coding, coverage, or payment that are consistently requiring ALJ hearings. This information would provide information regarding steps that should be taken to reduce ALJ requests.
2.) The ALJ process should handle claims that are requested "On the Record" first. This should eliminate scheduling a time for a hearing. Quite often the documentation speaks for itself and there is no need for a teleconference hearing.
3.) The ALJ process should incorporate an electronic tracking and submission system. Suppliers should be able to submit the ALJ requests through a portal and have the ability to check the status on a real time basis.
4.) The ALJ process should allow for the supplier to fast track higher dollar amount appeals. Having these high dollar amounts in the appeals process for an extended period of time creates severe financial hardship for suppliers.
5.) All of the ALJ offices should have the same procedures. As of right now they do not. Claims that are sent to Miami are treated differently than claims sent to other ALJ offices.
6.) There should be a time limit for ALJ offices to respond to emails and voice mails. Right now it is extremely difficult to get anyone to return a call from a supplier for status. If an online tracking system was implemented this would not be an issue.

Moving Forward

Thank you for your serious consideration of the above comments and recommendations. We look forward to the opportunity to continue collaboration through related follow up discussions and meetings.

Sincerely,

Don Clayback

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