

## Why California Medicare Appeals Should Go East

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After a Medicare reimbursement appeal moves through the Provider Reimbursement Review Board and potentially the CMS Administrator, a dissatisfied provider's next step is to file an appeal in the United States District Court. By statute the provider may choose to file its appeal either in the judicial district where it is located or in the District of Columbia.


Over the years I have heard many reasons both for or against the local district court or the District of Columbia. In an article published in the Winter 2011 issue of the *Administrative Law Review*, prominent administrative law professor **Richard J. Pierce, Jr.** explains why, in an administrative appeal, the petitioner (or Medicare provider), with all other things being equal, is better off filing in the District of Columbia.

Every empirical study that has looked at the issue found that the D.C. Circuit is less deferential to Federal agencies than any other circuit. The D.C. Circuit decides over a quarter of the cases in which agency action is reviewed. One study found that the D.C. Circuit affirmed agencies in 12% fewer cases than other circuits in 1984. A second study found that the D.C. Circuit affirmed agencies in 11% fewer cases than the other circuits from 1996 through 2006.

Professor Pierce identifies several persuasive reasons for the D.C. Circuit's greater likelihood to rule against an agency. First, the D.C. Circuit has a greater familiarity with the subject matter of administrative appeals. A regional circuit court may have a Medicare appeal once every few years; the D.C. Circuit has several every year. The judges of the D.C. Circuit will be more familiar with the law and operations of the agency, and may be more likely to challenge than to defer to an agency's interpretation. This point is supported by a further study that shows that circuit courts have lower affirmance rates with respect to the agencies they frequently review.

Second, the D.C. Circuit has a lower case load. The D.C. Circuit decides less than one quarter of the average number of cases per judge when compared to the regional circuit courts. Administrative records are often long and burdened with specialized terms and foreign concepts. One court famously characterized the reading of the Medicare statutes and regulations as "wrestling with water." The D.C. Circuit can devote more time to the understanding of the case. Not surprisingly, D.C. Circuit decisions are much longer than those in regional circuits.

Finally, the D.C. Circuit's lesser deference to agencies may be due to its composition. It is one of only three courts to which the President nominates judges of his choice, in contrast to regional circuits where the President nominates judges favored by the Senators or Governor of the state. This may result in judges with more powerful political or ideological perspectives. Some of the judges may also have greater judicial ambition. Four of the current members of the United States Supreme Court were promoted from the D.C. Circuit.

The empirical data shows that the D.C. Circuit is generally a better bet for providers in their Medicare appeals. The analysis of what likely drives this empirical result makes sense. Be aware of this article and its analysis and use it with your counsel in deciding where to file your Medicare appeal. Compare the analysis in Professor Pierce's article with any compelling reasons for filing your appeal in your local district. 

## Payer Accountability - A Critical Element in Your Denial Management Process

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Denial management has been the buzz in healthcare finance for over a decade now. An entire industry of IT services and solutions has been built for the purpose of tracking claim denial reasons, identifying the source of the denials, and quantifying the financial impact of the denials. Hospitals around the country have formed denial management teams or committees to review and analyze the information gathered by these IT solutions and to implement processes to prevent future denials. Yet the denials and lost revenue opportunities keep occurring. Why? A lack of accountability.

Enough has been said about the need to hold the various department heads within a hospital organization accountable for their department's role in the hospital's revenue cycle. However, there is not enough attention placed on the payer as an important stakeholder in your hospital's revenue cycle and the need to hold the payer accountable for its actions. Claims denied in error, delays in reviewing appeals, and untimely release of payment on overturned denials all contribute negatively to your bottom line. To make your denial management efforts more effective, we suggest the following:

**1. Understand the payers' commitments.** In order to do business, a payer commits to transact business according to various guidelines. It is important that your staff members understand the existence of these guidelines and that they govern how claims are to be processed. These guidelines are set out in:

- the state insurance rules and regulations,
- the summary plan description,
- the members' policy documents,
- the contract with the hospital

**2. You can't manage what you don't measure.** Payer report cards can be a very powerful tool. Develop key metrics to measure your payers' performance and share the results with the payers, as well as your internal stakeholders, on a monthly basis. Metrics to be measured, quantified based on volume and dollars, include:

- Number of denials received
  - Drilldown to the denial specifics:
    - ▶ Type of denial: clinical versus technical
    - ▶ Type of service/admission: ER, inpatient, outpatient
- Number of denials appealed
- Number of denials overturned/upheld
- Number of accounts and dollars with appeals and payments outstanding more than a specified period of time
- Average time between denial overturn date and payment issue date

Everyone wants to be top of the class. Compare payers in the key metric measurements and share the results with each of the payers.

**3. Holding others accountable is 90% communication, 10% consequences.** Consistent communication with your payers is vital to decreasing denials and increasing revenue capture.

- Provide the report cards to your payers on a monthly basis.
- Establish a set schedule of meetings with your payers to review the results of the report cards.
  - The frequency of the meetings should be dictated by the results of the report cards, not the convenience of the payer.

Continued on page 10