Administrative Review of Certain Electronic Health Record Incentive Program Determinations

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Final Rule (Final Rule), C.F.R 42 § 495.370 (2010) contains requirements for a Medicaid appeal process, but does not establish any such process for the Medicare EHR Incentive Program. The Centers for Medicare & Medicaid Services (CMS), Office of Clinical Standards and Quality (OCSQ) is providing this guidance as a step-by-step explanation on how a provider may file an appeal in the EHR Incentive Program.

Types of Appeals

OCSQ affords providers with a two-level appeal process including an informal review and a request for reconsideration. Within the two-level appeal process, there are three types of appeals that can be filed in the EHR Incentive Program: (1) eligibility, (2) meaningful use, and (3) incentive payment.

1. An **eligibility appeal** allows a provider to show that all the EHR Incentive Program requirements were met and that he or she should have received a payment but could not because of circumstances outside of the provider's control.
2. A **meaningful use appeal** allows a provider to show that he or she used certified EHR technology and is a meaningful user.
3. An **incentive payment appeal** allows a provider to show that he or she provided claims data for inclusion that was not used in determining the amount of the incentive payment and the incentive payment calculation is correct after a subsequent Federal determination determining otherwise.

Who may file each appeal type?

Providers	Eligibility Appeal	Meaningful Use Appeal	Incentive Payment Appeal
Eligible Professionals (EPs)	Yes	Yes	Yes
Eligible Hospitals	Yes	Yes	No (referred to PRRB[1])
Critical Access Hospitals (CAHs)	Yes	Yes	No (referred to PRRB[1])
Medicare Advantage Organizations (MAOs) on behalf of Medicare Advantage Eligible Professionals (MA-EP)	No (reviewed by CPC[2])	Yes	No
Medicare Advantage -Affiliated Hospitals	Yes[4]	Yes	No (referred to PRRB[1])
Medicare and Medicaid Dual-Eligible Hospitals	No (conducted by State[3])	Yes, only if adverse audit (conducted by CMS)	No (referred to PRRB[1])
Medicaid-Eligible Hospitals	No (conducted by State[3])	Yes, only if adverse audit (conducted by CMS)	No (referred to PRRB[1])

[1] PRRB - Provider Reimbursement Review Board
[2] CPC - Center for Drug and Health Plan Choice
[3] State – According to 42 CFR 495.370, the State has a process for a provider to appeal eligibility determinations.
[4] Only in an adverse audit verifying the MA-affiliated eligible hospital is under an MA organization's common corporate governance as defined in 42 CFR 495.200, and/or the MA-affiliated eligible hospital has less than one third of Medicare bed-days for the year covered under Part A rather than Part C.

Who can providers contact about appeals?

Any questions regarding the appeal process may be directed to OCSQ's designated appeals support contractor, Provider Resources, Inc. (Contractor).

Providers can submit inquiries on the appeal process via email or a toll-free hotline. If providers attempt to file an appeal through either of these two methods, the Contractor will provide instructions on how providers must file the appeal through the online web portal (portal).

- Email
  Providers may contact the Contractor through email, OCSQAppeals@provider-resources.com for general appeal questions and updates on the status of any pending appeals. The Contractor will monitor, track, and respond to provider emails during normal business hours.

- Toll-free hotline
  Providers may contact the Contractor through the toll free number, 855-796-1515 between 9 a.m. and 5 p.m. EST, Monday through Friday for general questions on how to file appeals, types of appeals, and the status of any pending appeals. For general questions on the EHR Incentive Program, the Contractor will transfer provider calls to the EHR Information Center.

Providers must use the portal to file appeals, reconsideration requests, and supporting documentation. Providers can also check the status of appeals through the portal. If the portal is unavailable, providers may contact the Contractor via the email or a toll-free hotline for additional information on how to file an appeal.

- Portal
  Providers can access the portal through the following link: https://ehrappeals.provider-resources.com. For questions on using the portal, providers should contact the Contractor.

General filing requirements for an appeal filing

Providers must meet general filing requirements for any appeal that is filed.

1. **General Rule One - All relevant issues raised in the initial appeal:** Providers must raise all relevant issues for each appeal type listed above at the time of the initial filing of an appeal. Except in very limited circumstances, issues that are not raised in the initial appeal cannot be raised at a later time and will be dismissed.

   Amendments only for extenuating circumstances: Providers may amend the appeal once if they can demonstrate an extenuating circumstance existed that prevented them from raising all relevant issues for each appeal type filed in the initial appeal.

   Filing Action – Amendments: Providers have 15 days from the date of the initial appeal filing to amend the appeal. The amendment must be filed in the portal.

   Review of the amendment will extend the 90-day informal review process for appeals by at least 15 days.

Withdrawing an Appeal: Providers may withdraw an appeal through the portal without reason at any time after the initial filing and before an informal review decision is issued. If a provider withdraws an appeal, it can be re-filed but only before the applicable appeal deadline under general rule two below.

2. **General Rule Two - Deadlines for filing appeals:** All appeals must be filed by the applicable appeal deadline.

   Filing Action – Late requests dismissed: Appeals filed after the deadline will be dismissed without the ability to re-file. If the deadline falls on a Saturday, Sunday, or a Federal holiday, the period for filing will be extended to the next business day. Appeals must be filed by 8 p.m. EST to be considered timely. Appeals filed after such time are considered filed on the next business day.

   The deadlines are as follows:

   Eligibility Appeals: Appeals for eligibility must be filed no later than 30 days after the two month period following the payment year. For example, eligible hospitals have until December 30, 2011 and EPs have until March 30, 2012 to file an eligibility appeal for payment year 2011.

   Meaningful Use Appeals: Appeals for meaningful use must be filed no later than 30 days from the date of the demand letter or other finding that could result in the recoupment of an EHR incentive payment

   Incentive Payment Appeals: Appeals for incentive payments must be filed no later than 60 days from the date the incentive payment was issued or 60 days from any Federal determination that the incentive payment amount was incorrect (including determinations that the payment was duplicative).

   Extension of deadline in extenuating circumstances: In very limited circumstances, a provider may file a request to extend the deadline and must show that extenuating circumstances existed that prevented the filing of an appeal by the deadline.

   CMS may extend the filing deadline for providers in order to respond to extenuating circumstances that occur within the program. CMS will provide information on its website at least seven days before the filing deadline and include the new date or dates that providers are required to file an appeal.

Issues precluded from review:

The following issues when raised within an appeal filing will be precluded from an informal review.

1. **Issues precluded from judicial and administrative review:** The Final Rule implementing the EHR Incentive Program precludes administrative or judicial review of the methodology and standards that determine eligibility to participate in the incentive program and that determine the incentive payment amount for EPs, Eligible Hospitals, or CAHs. For additional guidance refer to the following citations in the Code of Federal Regulations:
   - 42 C.F.R. § 495.110(a)(1-6) (2010), EP
   - 42 C.F.R. § 495.110(b)(1-5) (2010), eligible hospital

- 42 C.F.R. § 495.212(a) (2010), Medicare Advantage (MA) EP
- 42 C.F.R. § 495.212(b) (2010), MA-affiliated eligible hospital

Appeals dismissed: An appeal seeking to review the methodology and standards will be dismissed.

2. **Issues raised on appeal that are premature or inchoate:** Appeal issues are premature or inchoate if providers are challenging an issue that still has an opportunity to be resolved by CMS before the end of the two month period following the respective payment year for which the appeal is filed.

   Providers can re-file the issue in a subsequent appeal filing within the respective payment year deadlines when they can demonstrate: (1) they have met EHR Incentive Program requirements and should have received an incentive payment for the payment year for which the appeal is being filed, (2) CMS had an opportunity to resolve the issue raised in the initial appeal prior to the end of the payment year for which the appeal is being filed, and (3) CMS was not able to resolve the issue prior to the end of the payment year for which the appeal is being filed. When re-filing this issue, the appeal must challenge the same issues from the dismissed inchoate or premature appeal and must be filed no later than 30 days after the two month period following the payment year for which the initial appeal was filed.

3. **Issues raised on appeal involving a hospital cost report:** Appeals involving hospital costs reports must be reviewed by the PRRB. Providers will be notified by both phone and email to submit challenges regarding any hospital costs reports to the PRRB. CMS is not responsible for any provider missing the PRRB filing deadlines.

Decisions and reconsiderations:

1. **Informal Review Decision:**

   Within 90 days of the provider filing the appeal, an informal review decision will be made on issues raised in the appeal.

   During a case review under the informal review process, the Contractor will gather evidence from various sources to review and validate the information filed with the specific appeal. The Contractor may request supporting documentation from providers that is considered essential to complete the case review. Providers will have seven calendar days to comply with the request for supporting documentation. If a provider fails to respond to the request, CMS may dismiss the issues raised in the appeal filing, and the provider will not have the opportunity to re-file those same issues in a new appeal for that payment year.

   Providers are strongly advised that if they have questions about providing documentation or issues regarding specific requests to contact the Contractor to possibly prevent any appeals from being dismissed.

2. **Requests for Reconsideration:**

   The Contractor will notify providers by certified mail regarding the informal review decision and provide information on how to file a request for reconsideration, if applicable. Providers have 15

days from the date of the informal review decision to request reconsideration. Providers must file a request for reconsideration through the portal. If the request cannot be filed within the 15-day period, providers may request a one-time extension of 15 additional days.

3. **Final Decision:**

CMS will review the request for reconsideration and make a final decision within 10 days. The Contractor will notify providers of the final decision made by CMS. If providers choose not to request reconsideration, the informal review decision will be deemed a final decision.

Providers must exhaust any and all EHR Incentive Program challenges through the appeal process for providers established by CMS.