

**First Friday Clinician Outreach Meeting**  
**Moderator: Dr. Eugene Freund**  
**February 7, 2020**  
**1:30 pm ET**

Coordinator: Welcome and thank you for standing by. Your lines have been placed on a listen-only mode until the question-and-answer session. At that time if you would like to ask a question, you may press Star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. And now I'll turn the call over to Eugene Freund. You may begin, sir.

Eugene Freund: Hi, and welcome to this February edition of the First Friday Clinician Outreach meeting. Thank you all for (joining). I do have a brief announcement before we get started. I do remind you that this meeting is informational only and not intended for the press. Anybody is welcome to call in, but if you have press conferences, you need to contact [press@cms.hhs.gov](mailto:press@cms.hhs.gov) and we can set you up with contacts that you can address.

Anyway, we're going to start out with a brief open payments update from (Amy Hammons) of our Center for Program Integrity.

(Amy Hammonds): Thank you and hi everybody. Just a few updates on the open payment side of things. For those of you that might not be familiar with our program, just to let you know it's a National Transparency Program that requires that transfers of value by drug device, biological and medical supply manufacturers that are made to physicians and teaching hospitals are published on our public Web site.

One recent activity that we just simply did is our annual data refresh. That was done on Friday, January 17. And in this update it included changes to records,

delay in publication, slides that were changed, changes to disputed records and any adjustment to records that were deleted in the previous publication.

As a reminder for our program cycle, we publish the data annually on June 30. We're required to publish it on or by June 30. For example this coming year on June 30 of 2020 will be publishing the Program Year 2019 data. Speaking of that, the applicable manufacturers and group purchasing organizations have started their data submission to us. So they have already begin submitting their payments. That includes payments that they made from January 1 of 2019 through December 31 of 2019. And they will have until March 31 of this year to do that.

Following the data submission period is when the prepublication review and dispute period opens for physicians and teaching hospitals. And so that's my next big reminder for everybody is that if you aren't already registered in the open payment system, I would recommend doing that or doublechecking that you have access to your account. Then that timeframe will be here before we know it. We are on track for the review and dispute period to open on April 1 and continue through May 15 which are our normal dates. But again, I would just say be mindful of those dates. So time is definitely flying by.

And if you would need to reactivate an account, you need to do this by calling our help desk and I'll give you the phone number for that. It's 1-855-326-8366 and right now they're operating extended hours. So they're open 8:30 a.m. to 7:30 p.m. Eastern Standard Time.

And the final announcement that I have from the open payment side of things is we are going to be hosting our annual National Provider Call on Thursday, March 19 from 2:00 to 3:00 and this will provide an opportunity to learn the details of the program including how to register and actions that you can take

during the prepublication review and dispute process. Call details will be put out through our listserve and also they will be provided through the CMS Medicare Learning Network.

And those are all of my updates for today. Thank you.

Eugene Freund: Do we have any questions for Ms. (Hammonds)? Star 1 is how you can raise your hand to ask questions.

Coordinator: Thank you. Again, if you have a question, just press Star 1 and record your name clearly. Again, Star 1 and one moment, please. At this time, I'm showing no questions.

Eugene Freund: Okay, we can move onto our next topic. We have David Dolan and Dr. Susan Miller from our Center for Clinical Standards and Quality who will be addressing coverage of acupuncture for chronic low back pain.

(David Dolan): Good afternoon, everyone. I just want to confirm. (Susan) are you on?

Dr. (Susan Miller): Yes, I am.

(David Dolan): Okay, great. So what I'll do is I'll just give a high-level overview of the decision and (Susan) can fill in any gaps I may have missed. And we'll turn it over for questions then. But effective on January 21, 2020, CMS will cover acupuncture for chronic low back pain. It will cover up to 12 visits in 90 days with an additional eight sessions covered for the patients that are demonstrating improvement, but no more than 20 acupuncture treatments may be administered annually.

So physicians may furnish acupuncture in accordance with their state requirements. We also allow for physician assistants, nurse practitioners, or clinical nurse specialists and auxiliary personnel to furnish acupuncture if they meet all of their state requirements. And they also have a master's, a doctoral level degree in acupuncture or oriental medicine from a school accredited by the ACAOM and also have a current full active and unrestricted license to practice acupuncture in the state, territory or commonwealth of the US or District of Columbia.

And auxiliary personnel that are furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurses practitioner or clinical nurse specialist as required by regulations at 42CFR410.26, 410.27. This is all in the decision memorandum that posted on the 21st. And all types of acupuncture including dry needling for any other condition besides chronic low back pain remain noncovered by Medicare.

So that's a high-level overview and if (Susan) doesn't have anything she'd like to add regarding the decision, we'd be happy to turn it over for questions.

Dr. (Susan Miller): Let me just add that there is a definition of chronic low back pain meaning that it has lasted 12 weeks or longer. That it has no identifiable systemic cause, is not associated with surgery or pregnancy.

And now if anybody has any questions, we're happy to try and answer them.

Coordinator: Thank you. Again, if you'd like to ask a question at this time, just press Star 1. And one moment, please. We do have a question coming in. One moment, please.

And that questions comes from (Ronald Hirsch). Your line is open. You may ask your question.

(Ronald Hersch: Hi, there. Just a simple question. When you talk about the pain in duration of 12 weeks, is that 12 weeks under treatment or is it historical 12 weeks and as long as the doctor writes pain for three months it's going to be covered? Thank you.

Dr. (Susan Miller): The clear reading of the National Coverage Discrimination would say that it is 12 weeks.

(Ronald Hirsch): Of history, not of active treatment.

Dr. (Susan Miller): True.

(Ronald Hirsch): Okay, thank you.

Coordinator: Thank you. At this time, I'm showing no further questions.

Eugene Freund: Okay, thanks a lot for coming on and talking about that. Our last session in the queue is a listening session on the claims appeals process. We have David Danek and (Liz Hosna) from our Center for Medicare on. We sent a little bit of verbiage on, but we'll let them give us a brief overview of what they're looking for and then open up the floor for discussion.

David Danek: Thanks, Dr. Freund. So as most of you know, CMS has had several initiatives aimed at improving the provider experience in the claims appeal process. These have been primarily focused on reducing backlogs at the ALJ level. And they've been in place for a couple of years now. So at this point we wanted to take a look at the levels that precede the ALJ and give stakeholders

an opportunity to share their ideas and recommendations on structural or process changes and improvements at the MAC redetermination level and at the QIC reconsideration level.

We are limited in the kind of changes we can implement as the statutory provisions that govern the claims appeal process are fairly prescriptive. So we hope your recommendations will take that into account. But, you know, with that I don't want to waste a whole lot of time and want to have as much time for you to share your ideas.

First, I'll just ask if there's any questions about the goals here, what we're trying to accomplish. And then open the floor up for your recommendations and ideas. So I guess we can first start with that. Any process questions for this?

Coordinator: Again, just press Star 1 at this time if you have a question. And one moment, please.

We do have a question from Edward Hu. Your line is open. You may ask your question.

Edward Hu: Thank you. As I was getting in the queue, I think I missed some of what you had already... I think you are asking now about any questions about the process. My first question is so at Level 1 and Level 2, the regulations state that it should be an independent review. My question is, is it supposed to be an impartial review or is it not an impartial review? Or is that not part of the equation here?

David Danek: I mean it is an independent review and it's a review by persons other than those that reviewed the initial determination at the claim level. You know,

they are independent finders of fact, so, you know, we expect them to be impartial. They are bound by certain, you know, parts of the LCD and manuals at the first level. And then they give substantial deference at the second level. So there are authorities that bind them, but, you know, these are independent decisions outside of CMS that, you know, we have no involvement in. I don't know if that answers your question.

Edward Hue: It does, thank you. Mostly, I think, I had wanted to make a comment on how to improve the process, but I think that's- you're going to open the floor in just a moment for that. So I'll get back in queue then.

David Danek: Sure.

Edward Hu: Thank you.

Coordinator: Thank you. And at this time...

David Danek: Yes.

Coordinator: Go ahead, sir.

David Danek: Sorry.

Coordinator: I was going to say, at this time I'm showing no further questions.

David Danek: Okay, then let's open up the floor to hear your ideas, recommendations for improvement, kind of process, structural types of things. So, all right, so yes, let's open up the lines. Thanks.

Coordinator: Thank you. And again just press Star 1 at this time if you'd like your line opened. And again, Edward Hu, your line is open. You may ask your question.

Edward Hu: Hello, again. I hope I'm not the only person providing feedback, but I do appreciate the opportunity to do so. You know, having worked with the appeals process for several years now, I think one of the things that would really be helpful is that many times when we get a redetermination or reconsideration back, we don't necessarily see that the reasoning that we put into our appeal request has necessarily been addressed. And I don't know if it's a matter of, you know, are we misinterpreting things incorrectly? Or are the reviewers going straight to the source documents and not considering the appeal letters? Or is it something having to do with, you know, application of an incorrect policy?

But many times the explanations that we get back and the unfavorable Level 1 and Level 2 appeals don't really give us very much descriptive information and so it leaves us wondering. And, you know, when we get the impression or when we think that perhaps somebody may not have understood what we were trying to say rather than, you know, pointing out where perhaps we have gone wrong, you know, it appears that it just wasn't addressed. And so therefore, sometimes we feel we need to take it up to the higher level such as to the third level of appeal.

So that was really one of the items. You know, I think clear language in the redetermination, reconsideration letters that explains that addresses the arguments that we make that why we think something should be payable or covered. And knowing that it is addressed and hearing that feedback may be able to decrease the number of cases that providers may choose to then move forward.



The other suggestion that I have, and to be honest our MAC does a pretty good job of this which is providing the credentials of the independent reviewer. But at Level 2 at the reconsideration level, usually it just says a panel of healthcare professionals. And so, you know, we're not really sure who reviewed that case or what the credentials. You know, was... did a physician review that case?

At the Level 1, typically... well sometimes it is a physician, but many times it's not a physician. There's not a prescription that I'm aware of that it needs to be a physician, but it would be helpful to know what the credentials of the reviewer was. So that we would know, you know, whether that person likely had the background necessary to understand the points either we were trying to make or perhaps to point out things that we missed that we didn't necessarily recognize.

So, with that I'll - I guess there's one more point that I wanted to make since this is a listening session. And I have brought this up with other individuals of CMS, but for non-contracted providers who have access or supposed to have access to the same five-level pathway with the difference that Level 1 instead of being with the MAC is actually with the plan itself.

We have found that our noncontracted providers are frequently not being afforded the CMS pathway for appeals and being sent down, sort of, a circular interminable dispute process which never gets out of the plan or never gets out of a subcontractor of the plan. So I don't think that's what's supposed to happen. And when these things happen, it tends to be addressed on a case-by-case basis but if that is correct or if that's not what's supposed to happen, how do we fix it for all of the noncontracted providers in the country?

So thank you for listening.

David Danek: And thank you for your very insightful and pointed comments. These are issues that, you know, we are aware of that we've worked on over time. And while we don't have experts in our Medicare Advantage appeals, we'll certainly pass this along to the folks there and let them know about this concern. So, thank you very much.

Nisha Sherry: Hi, Dave, this is Nisha and I can speak to that as well. Ed if you have specific examples, we always welcome specific examples of this happening and that helps us understand some of the root cause issues there. So if you could forward those to me, that would be great. I'm at [Nishamarie.sherry@cms.hhs.gov](mailto:Nishamarie.sherry@cms.hhs.gov).

Edward Hu: Okay, great. I'm sorry. I didn't catch the spelling of the name. I just want to make sure that I get it right so that it gets to you.

Nisha Sherry: It's Nisha Marie, N-I-S-H-A-M-A-R-I-E dot Sherry, S-H-E-R-R-Y at CMS dot HHS dot gov.

Edward Hu: Great, thank you. I will send some examples.

Nisha Sherry: Thank you. Thanks so much.

Coordinator: Thank you. Again, just press Star 1 to have your line opened. Our next question comes from Matt Reiter. Your line is open.

Matt Reiter: Hi, thank you so much for holding this listening session. I'm calling on behalf of the Healthcare Business Management Association, or HBMA. And this is

an important issue to HBMA members, so we're thankful for the opportunity to provide feedback.

So I did... circulated this request to some of our members and I got some feedback. And I'm hoping to get some more, so I'm hopeful that the email address that was just given out can be a way for us to follow up with more specifics that I know the CMS folks always ask for. So happy to follow up with more information after these comments.

The first comment I would say is, at least for the first level of appeals at the MAC level, it's been the experience of some of our members really within a certain MAC that the redetermination process is not really much of a process at all. In fact, it's pretty much a rubber stamp unfavorable decision which means that it has to go to the next level. And sometimes, depending on the amount in question, it's not worth pursuing it at that next level.

So it- the comment I guess is that it seems like there's not much of a process at the MAC level sometimes. It's just a given that there's going to be an unfavorable determination. The second comment I'll make is that some of these issues are preventable in the first place specifically regarding LCDs and others and that sometimes MACs don't always implement those decisions correctly and we'll bring it to their attention and CMS's attention. And they'll acknowledge it and agree to fix it and it might take months to correct.

But also that, you know, these are avoidable issues in the first place. So we think that help cut down the backlog and help cut down on the need for these appeals that if there was... there is an opportunity to prevent them in the first place. Thank you.

David Danek: Thank you, Matt. Yes, those are also, you know, very pointed issues that we are aware of that we do work on with our MACs but we appreciate hearing that feedback here. So, thanks.

Matt Reiter: Of course, and do you want us to provide some additional feedback or examples, we're always happy to. You can always reach out to us.

David Danek: Yes, as you... if you get additional ideas from your members, yes, you can certainly pass those along. I'll give you my email address as well. And that's David, D-A-V-I-D dot Danek D-A-N-E-K at CMS dot HHS dot Gov.

Matt Reiter: Great, thank you so much.

Nisha Sherry: And thanks, David. This is Nisha again. Also for everyone on the phone, we actually have a portal, a mailbox portal and it's sometimes best to submit questions, examples to that mailbox. So if either of us are out, there are subject matter experts that can address those issues. And that address is [appeals.lmi.org](https://appeals.lmi.org). But again if there's any problems with submitting any information, you can reach out to myself or to Dave.

Coordinator: Thanks, we do have a question or comment from (Ronald Hirsch). Your line is open.

Ronald Hirsch: Hi, there. I got a couple things. First, I'd like to echo Dr. Hu's comments especially about the Medicare Advantage plans. We find that nationwide, they really just run rampant over hospitals. They obviously know who's contracted and who's not contracted with them. Yet when there are - they issue denials, they totally ignore that fact and try and subject the hospitals to in-network policies for appeals rather than the noncontracted appeal process.

So I understand that Medicare Advantage is growing and that the administration likes it, but it's really - it's causing lots of friction, lots of anguish in hospitals.

My second comment really follows up on what was just said by Matt about the MACs and the LCDs. Recently it came to light that Noridian is still enforcing the LCD, excuse me, the NCD for TAVRs, transcatheter aortic valve replacement which requires two cardiac surgeons to review the patient's case before the surgery. That requirement was removed by CMS in June of last year, but even as early as two weeks ago they put out a notice that they are enforcing that.

So it just seems to me that the MACs should be a little more up to date on what CMS is publishing. The other issue that came up is with the (unintelligible), so augmentations. And there's several MACs that come out in LCD that requires a multidisciplinary team including the radiologist and neurologist to review the case and determine if the procedure is necessary. There is no way that a radiologist would ever be consulted to determine whether a procedure is necessary or not.

So the MACs are putting in requirements that have nothing to do with medical care and are completely medically unnecessary to put up roadblocks to allow procedures to be done that have proven efficacy in specific cases. So again, I think CMS really needs to provide oversight of these contractors. They really just need to (unintelligible). Thank you.

David Danek: Thank you, Dr. Hirsch. We certainly appreciate those comments, and we will try to get them to the right folks that deal with contractor oversight. And certainly the MA plan issue is one that our area has responsibility for. So do appreciate that.

Ronald Hirsch: Thank you.

Coordinator: Thank you, and again just press Star 1 to have your line opened. Our next question or comment comes from Brian Moore. Your line is open, sir.

(Brian Moore): Yes and thank you for opening up this session and listening to some feedback. I'm going to echo some of the concerns that were brought up by Dr. Hu and Dr. Hirsch. And it is regarding MA plans. I've done probably over 200 appeals of MA plan, pre- benefits. And I have escalated this already to other areas inside of CMS, but you know, unfortunately it is not uncommon to have the plans misquote the regulations and it's very difficult to have accountability for this.

I have filed grievances with the plans. I have escalated these grievances to CMS because these grievances have not been responded to in writing or really even acknowledged by the plans. And this is going on now for about nine months is the longest grievance I have, I believe or almost a year at this point. But, you know, there are significant process issues. And I don't know who else to escalate this to, but these grievances are not getting resolved and per the regs, they're required to provide a written response within 30 days of filing the grievance.

And the actions that I am seeing are when an expedited appeal is initiated by a physician, that the plan unilaterally is able to downgrade it to a standard appeal. And then do not give adequate notification. They do not give the ability to file an expedited grievance to have that determination challenged. I know CMS is looking into this, but there hasn't been closure from the plan. And I've escalated a number of issues to the plans with the grievances and the plans are not responding the way they're supposed to with the regs.

And I'm just wondering, you know, as a provider similar to what Dr. Hu described where, you know, if you're not contracted, the plan just doesn't allow access to your, you know, five-level appeal rights. What do you do when they just say no? And you've escalated it to CMS, and they don't respond to grievance. What is the appropriate response at this point? How else can we sound the alarm to say if patients are trying to get their appeals or grievances answered. I can't imagine that they have any more success than what I've had, and this is not getting resolved or better.

So any guidance on where else to escalate this to is appreciated.

Nisha Sherry: Hi, was that Dr. Moore that was just speaking?

(Brian Moore): Yes.

Nisha Sherry: Hi, Dr. Moore, Nisha Sherry. Appreciate your comments. Thank you so much. And yes, we are aware of your concerns. We've actually reached out to the plans to follow up on what is outstanding and what has been addressed thus far. There is some - I would appreciate if you could send the information or copies of the grievances that you've submitted to each and name exactly the plans, because I think there's some misinformation on our part about which plans are involved. If you want to submit that to the mailbox that I mentioned before, the [appeals.lmi.org](https://www.appeals.lmi.org). And then I can follow up with you separately next week after we receive the information regarding next steps.

(Brian Moore): Okay, and just the concern I have. So I will do that. I have submitted this to CMS a number of times. Do you want me to forward you the information I have already submitted to CMS or do you want the original grievances I filed with the plans?

(Nisha Sherry): I think what would be most helpful is the original grievances that you filed with the plans because we - I know that we have the information that you've sent thus far. We followed up with some of the plans, but I believe we may be missing some of them. And it would be helpful if we could have copies of the actual grievances.

(Brian Moore): Okay, because the plan called me and they couldn't locate the grievances despite me having confirmed receipt of them. So I'll send those to you then. Thank you.

(Nisha Sherry): Thank you.

Coordinator: Thank you, and at this time I'm showing no one in the queue. Again, if you'd like your line opened, you can press Star 1. And one moment, please. At this time, I'm showing no further questions or comments.

David Danek: Okay, well I want to thank everyone for providing us with this feedback. You know, there are a few new issues that we will take a look at, and you know, we'll have to figure out where we go from there in terms of, you know, improving some things on the contractor side, for an MA side that, you know, Nisha will certainly be working on that. And then, you know, if there is additional information, additional comments from members, we'd certainly welcome that either to the email addresses that we provided or probably, I think Nisha's recommendation to use [appeals.lmi.org](https://www.lmi.org) might be the best solution to make sure it gets tracked and responded to.

So again, thank you for taking the time, soliciting membership, and for some good insightful information.



Eugene Freund: David, just one quick question. This is Gene Freund again. So it is appropriate to use [appeals@lmi.org](mailto:appeals@lmi.org) for questions about both original Medicare and problems with the Medicare Advantage appeals processes?

Nisha Sherry: Hi, Dave. I can address this. The - it's actually - it's a Web portal and it's [appeals.lmi.org](https://appeals.lmi.org). And once you get to the portal page, there's a Part D mailbox, a Part C mailbox and there's a BNI mailbox. For issues regarding original Medicare appeals we recommend that you submit them to the BNI mailbox. And then for managed care if it's a MA plan, Part C. If it's a prescription drug plan, Part D.

If you submit to any of those mailboxes, we'll still receive it. But that would streamline it for us. I hope that answers the question.

Eugene Freund: Okay, thank you. Yes, I heard appeals at. It's appeals dot lmi dot org. I just...

Nisha Sherry: Yes.

David Danek: Yes, I apologize for that. That's me showing my lack of experience with this and my, unfortunately my lack of understanding of the portal. So I do apologize.

Eugene Freund: Okay, well that's great information from you all. Thank you very much for both C, D and trad..., and original Medicare. So...

Coordinator: We do have a question, couple of questions or comments if you'd like to take them.

David Danek: Sure.

Coordinator: Thank you. And one comes from Brian Moore. Your line is open, sir.

(Brian Moore): Thank you, again. Follow up, some of the problems has been in communicating with CMS has been the inability to open up secure emails when you're sending sensitive patient data. What is the best way to get these cases to you if I'm sending to an email? Will people be able to open up information that is sent secure? Because what I've had to do is manually fax to secure faxes often. And so just if I could understand how to submit this information so that you can actually open it and access it, because it's going to have patient information in it.

Nisha Sherry: Brian, sorry, Dr. Moore, Nisha again here. So if it's - is it protected information that you're sending encrypted or is it not encrypted?

(Brian Moore): It's encrypted.

Nisha Sherry: It's encrypted. So you can - if you can submit it through the portal and upload it and it's encrypted, I would try that mechanism. If that doesn't work and we're unable to open it, we can follow up - I can follow up with you directly. And work out how we would get that information.

(Brian Moore): Okay, I will send it encrypted to you - to the portal then, thank you.

Nisha Sherry: Thank you.

Coordinator: Thank you. And Ronald Hirsch your line is open.

(Ronald Hirsch): I just want to point out now that I understand the portal you're talking about, Nisha. With the new detailed notice of discharge and important message changes, whoever's been manning the BNI part has been absolutely amazing

in providing responses. You know, we're used to waiting days and weeks. These come back, you know, the strangest hours. So, you know, kudos to whoever's doing that work and the providers really appreciate the responsiveness. Thank you.

Nisha Sherry: Well thank you so much, Dr. Hirsch. I will make sure to relay that to my team that receives that mailbox.

David Danek: It's always gratifying when we get kudos. Thank you.

Coordinator: And at this time I'm showing no further questions or comments.

Eugene Freund: Okay, well thank you all very much for calling in. Thanks to all the speakers for joining us today. And we'll put next - the next meeting March 6, 2020, on the agenda and look forward to conducting this again in a month. So, thank you very much and this concludes the February First Friday Clinician Outreach Meeting.

Coordinator: Thank you, and this does conclude today's conference. We thank you for your participation. At this time, you may disconnect your line.

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