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Health Headlines

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CMS Issues Guidance on Appeals for EHR Incentive Program Determinations

The CMS Office of Clinical Standards and Quality (OCSQ) issued guidance last week outlining the procedures for appealing determinations made under the Medicare Electronic Health Record (EHR) Incentive Program. The guidance establishes a two-level appeals process—an informal review and a reconsideration—for both eligible hospitals and eligible professionals (EPs) to challenge (i) eligibility determinations, (ii) meaningful use determinations, and (iii) incentive payment calculations.

More specifically, these appeal categories consist of the following:

1. An eligibility appeal allows a provider to show that all the EHR incentive program requirements were met and that the provider 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 the provider is using certified EHR technology and met the meaningful use objectives and associated measures after a successful attestation.

3. An incentive payment calculation appeal allows an EP to show that he or she provided claims data for inclusion that was not used in determining the amount of the incentive payment. (Only EPs are permitted to use the process to appeal incentive payment calculations. CMS's guidance states that it will develop procedures to permit eligible hospitals and CAHs to appeal these disputes to the Provider Reimbursement Review Board.)

OCSQ has designated Provider Resources, Inc. (Contractor) as the contractor responsible for handling and providing support to providers seeking information regarding the appeals process. The Contractor, which can be reached by email at OCSQAppeals@provider-resources.com or by calling 855-796-1515, provides answers to general appeal questions and updates on the status of pending appeals.

Both informal review and reconsideration appeals must be filed using the Contractor's online portal which can be accessed at https://ehrappeals.provider-resources.com. The following two general rules apply to EHR incentive payment program appeals:

1. **General Rule One:** Except for limited extenuating circumstances, providers must raise all relevant issues for each appeal type at the time of the initial filing for an appeal.

2. **General Rule Two:** Except for limited extenuating circumstances, all appeals must be filed within the following deadlines:

    - Eligibility appeals must be filed within 30 days following the close of the attestation period.

- Meaningful use appeals must be filed within 30 days from the date of the demand letter or other finding requesting recoupment.

- Incentive payment appeals must be filed within 60 days from the date the incentive payment was issued or 60 days from any finding that affects the incentive payment.

According to the guidance, the following issues are not appealable:

1. Issues that involve the methodology or standards that are used to determine eligibility for the incentive payment amount;

2. Issues that are premature or inchoate because the they can still be resolved by CMS before the end of the payment period for which the appeal is filed; and

3. Issues that involve a hospital cost report, which must be reviewed by the PRRB.

Informal review decisions will be made within 90 days of filing. During informal reviews, the Contractor gathers evidence from multiple sources and may request supporting documentation from the provider. The provider must respond to any such requests for supporting documentation within seven days or face dismissal.

Following issuance of an informal decision, providers have 15 days to request reconsideration. If a provider is unable to file a reconsideration request within the 15 day deadline, it may request a one-time extension for 15 additional days. Final decisions on requests for reconsideration will be made within 10 days of receipt of the requests.

CMS's guidance on EHR incentive payment appeals process is available here and here.

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