HHS Issues Final Rule to Address Record High Medicare Appeals Backlog

(January 20, 2017): The Medicare appeals backlog has reached its all-time worst. If you're a healthcare provider or supplier waiting for a hearing before an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Medicare Appeals (OMHA) – the third level of the Medicare appeals process – you've likely been waiting years to have your case heard or, at least, you're expecting such a wait. This wait time has persisted despite that ALJs are statutorily required to issue a decision within 90 days of receipt of a hearing request. The reasons for the backlog depend on who you ask: the American Hospital Association (AHA) and others have contended that the Recovery Audit Program is the "*primary culprit in creating and sustaining*" the backlog because Recovery Audit Contractors (RACs) "*receive a cut of any improper payments they recover […] and can challenge claims going back as far as three years.*" The U.S. Department of Health and Human Services (HHS) agrees that the Recovery Audit Program has contributed to the backlog, but believes there are other reasons as well, like an increase in Medicare beneficiaries and a growing practice among some providers to appeal virtually every claim denial through ALJ review (coupled with only modest increases in funding for the agency, thereby limiting their ability to address the growing number of appeals and backlog).

I. Statistical Overview of the Medicare Appeals Backlog:

In any event, the statistics are astounding:

- ***The number of ALJ appeals filed grew 936%, from 41,733 to 432,534, between fiscal years (FY) 2010 and 2014.***
- ***By the end of FY2014, 767,422 appeals were pending at ALJ.***
- ***ALJ decisions are issued well after the 90-day statutory deadline: in FY2014, it took OMHA an average of 415 days to process an ALJ appeal; in FY2015, it took OMHA an average of 662 days to process an ALJ appeal; and in FY2016, it took OMHA an average of 877 days to process an ALJ appeal.***

The backlog has been a significant source of frustration for healthcare providers and suppliers (and their representatives) stuck in the lingering appeals process – and not just because it takes so long to achieve a final judgment by the Secretary. The delay often has significant financial consequences because Medicare can statutorily recover the alleged overpayment shortly after a second level (reconsideration) appeal decision issues, despite that the appeals process is not over and despite that the first two levels of appeal are littered with problems (e.g., we see chronic misapplication of Medicare coverage and payment rules by appeals contractors at the first two levels of appeal).

II. Order by the U.S. District Court:

Thanks to the efforts of AHA and other plaintiffs who sought relief in court, we may see the backlog resolve over the next few years. On 12/05/2016, the United States District Court for the District of Columbia ordered that the HHS Secretary reduce the backlog according to the following timeline:

- ***30% reduction from the current backlog of cases pending at the ALJ level by 12/31/2017;***
- ***60% reduction by 12/31/2018;***
- ***90% reduction by 12/31/2019; and***
- ***100% reduction by 12/31/2020.***

III. Other HHS Efforts to Address the Medicare Appeals Backlog:

In an effort to meet these mandated backlog reduction timelines, HHS issued a final rule on 01/17/2017 titled "*Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures*". The final rule includes an assortment of initiatives to reduce the backlog which become effective 03/17/2017, including:

- ***Giving select Medicare Appeals Council decisions precedential effect.*** The final rule provides that designated "*Medicare Appeals Council decisions [...] have precedential effect and are binding on all CMS components, on all HHS components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration to the extent that components of the Social Security Administration adjudicate matters under the jurisdiction of CMS*." This is significant because, currently, even if the Medicare Appeals Council interprets a Medicare authority or provision in a specific way in a decision, that interpretation only applies to the case at hand (even though the decision represents the final decision of the Secretary). In other words, an Appellant can't contend that the interpretation of a Medicare authority or provision in a previous Medicare Appeals Council

matter is binding in their case as well, even if the facts and issues are very similar. HHS hopes the precedential nature of Medicare Appeals Council decisions as of 03/17/2017 will create consistency in the appeals process. It's possible, though, that the discretion given to the Departmental Appeals Board (DAB) Chair to decide which cases have precedential effect may impact how effective this change will ultimately be.

- ***Expanding the pool of adjudicators at OMHA to include attorney adjudicators.*** An attorney adjudicator is a licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, and authorized to take the actions on requests for ALJ hearing and requests for reviews of QIC dismissals. HHS estimates that the expansion of the pool of adjudicators at OMHA could redirect approximately 24,500 appeals per year to attorney adjudicators who would be able to process these appeals at a lower cost than would be required if only ALJs were used to address the same workload.

- ***Creating process efficiencies.*** These include, for example, allowing ALJs to vacate their own dismissals rather than requiring Appellants to appeal a dismissal to the Medicare Appeals Council and using telephone hearings for certain Appellants.

For more information on these and numerous other initiatives, please refer to the Federal Register. The hope is that the finalization of this rule and the Secretary's accountability to the District Court – the Court retained jurisdiction of the case to review the quarterly status reports the Secretary is required to prepare and to rule on any challenges to unmet deadlines – will achieve the intended result: complete elimination of the backlog by 2020.

The Centers for Medicare and Medicaid Services (CMS) has taken steps in the past to improve the appeals process, and these steps have not always achieved the intended result. For example, with regard to appeals stemming from a post-payment review, CMS directed redetermination (first level) and reconsideration (second level) appeals contractors – effective August 2015 – to restrict their review on appeal to (in most cases) only the issues alleged by the reviewing contractor (i.e., the contractor that requested the records and issued the initial audit results). The purpose was to avoid a moving ball – where one Medicare contractor alleges one issue and the Appellant addresses it, but then another contractor alleges another issue, requiring the Appellant to then address a different issue with regard to the same claim. However, we have seen the redetermination and reconsideration appeals contractors repeatedly disregard this CMS directive and continue to try and add new denial reasons to the administrative record. We have also seen the initial auditing contractors increasingly allege more than one denial reason, throwing everything but the kitchen sink at providers and suppliers. It seems that Medicare is hoping for at least one denial reason to persist through the appeals process.

Judicial oversight is the difference this time around and could be the key to reducing the backlog. We'll be monitoring HHS's progress closely and hoping for expeditious relief for our current and future clients, and healthcare providers and suppliers everywhere.

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Sources:

AHA v. Burwell, 2016 U.S. Dist. LEXIS 126840 (D.D.C. Sept. 19, 2016).

AHA v. Burwell, 2016 U.S. Dist. LEXIS 167291, 2016 WL 7076983 (D.D.C. Dec. 5, 2016).

Federal Register, Volume 82, Number 10, Pages 4974-5140, "*Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures*" (01/17/2017). Available at https://www.federalregister.gov/documents/2017/01/17/2016-32058/medicare-program-changes-to-the-medicare-claims-and-entitlement-medicare-advantage-organization.

HHS, "*FACT SHEET: HHS Issues Final Rule to Improve the Medicare Appeals Process*".

HHS, OMHA, "*Average Processing Time By Fiscal Year*" (11/18/2016). Available at https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html#.