

MEDICARE APPEALS ADJUDICATION DELAYS: IMPLICATIONS FOR HEALTHCARE PROVIDERS AND SUPPLIERS

Jessica L. Gustafson, Esq.
Abby Pendleton, Esq.

The Health Law Partners, P.C.
Southfield, MI

On December 24, 2013, Nancy J. Griswold, Chief Administrative Law Judge (“ALJ”) for the Department of Health and Human Services (“HHS”) Office of Medicare Hearings and Appeals (“OMHA”) delivered the unsettling news to Medicare provider and supplier appellants: As of July 15, 2013, OMHA had “temporarily suspended the assignment of most new requests” for ALJ hearings. Despite statutory, regulatory and policy mandates to the contrary, OMHA anticipates that its suspension of ALJ assignments will result in a delay of approximately 2.5 years from the time a request for hearing is made until an ALJ hearing is held.¹ This article examines the reasons for the ALJs’ inability to adjudicate appeals within the mandated timeframe, the associated legal and financial implications for appellants, and potential resolutions to reduce or eliminate the backlog.

Overview of the Medicare Part A and Part B Appeals Process and Appeals Timeframes

Section 1869 of the Social Security Act (42 U.S.C. § 1395ff), created the five-stage uniform Medicare appeals process applied to Medicare Part A and Part B appeals. Regulations implementing this portion of the Social Security Act are codified at 42 C.F.R. Part 405 Subpart I, and the Centers for Medicare & Medicaid Services (“CMS”) sub-regulatory guidance related to Medicare Part A and Part B appeals is set forth in the Medicare Claims Processing Manual (CMS Internet-Only Manual 100-04),

Chapter 29.² Generally, the five-stage Medicare Part A and Part B appeals process is as follows:

Stage 1

Following receipt of an initial determination,³ a dissatisfied party may file a request for “redetermination.” A request for redetermination must be submitted in writing to the Medicare Administrative Contractor (“MAC”) that issued the initial determination. A request for redetermination must be submitted within 120 days following the date of receipt of notice of initial determination (a party will be presumed to have received the notice of initial determination five days after the date of the notice, unless there is evidence to the contrary).⁴ The MAC is required to conclude its redetermination review no later than the 60-day period beginning on the date the MAC receives the request for redetermination.⁵

Stage 2

If a party is dissatisfied with a redetermination decision, it may file a request for “reconsideration.”⁶ A request for reconsideration must be submitted in writing to the qualified independent contractor (“QIC”) identified in the redetermination decision.⁷ A request for reconsideration must be submitted within 180 days from the date the party receives notice of a partially favorable or unfavorable redetermination decision (a party will be presumed to have received the redetermination decision five days after the date of the notice, unless there is evidence to the contrary).⁸ Of significance to appellants, federal regulations require all evidence to be submitted at the reconsideration stage of review. If an appellant fails to do so, absent good cause, new evidence may not be submitted at subsequent stages of appeal.⁹

Unless good cause is shown, the ALJs, Departmental Appeals Board (“DAB”) Medicare Appeals Council (“Council”), and federal district court will limit their review to the evidence submitted at or before reconsideration. The QIC is required to conclude its reconsideration review no later than 60 days following the date it receives the reconsideration request.¹⁰ If the QIC fails to abide by this timeframe, a party may “escalate” its appeal to the ALJ stage of appeal, in essence bypassing the QIC reconsideration review.¹¹

Stage 3

If a party is dissatisfied with a reconsideration decision, it may file a request for ALJ hearing.¹² It is the mission of OMHA, in conducting ALJ hearings, to provide “a responsive forum for fair, credible and timely decision-making throughout an accomplished, innovative and resilient workforce... .”¹³ An appellant’s request for ALJ hearing must be submitted within 60 days of the date of a party’s receipt of reconsideration decision (a party will be presumed to have received the reconsideration decision five days after the date of the notice, unless there is evidence to the contrary).¹⁴ An amount in controversy requirement applies.¹⁵ The Social Security Act expressly requires that an ALJ “conduct and conclude a hearing on a decision of a qualified independent contractor...and render a decision on such hearing by *not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.*”¹⁶ If the ALJ fails to abide by this timeframe, a party may “escalate” its appeal to the Council for review.¹⁷ Notably, exercising the option to escalate an appeal from the ALJ stage to the Council for review is not a palatable option to many appellants and their healthcare

legal counsel. Appellants historically have been most successful at the ALJ stage of appeal.¹⁸ Accordingly, bypassing this stage of review would not be recommended.

There are circumstances where the statutory 90-day adjudication period for ALJ appeals is extended. In some cases, these exceptions could result in a significant adjudication delay. For example:

(1) If an appeal is escalated to the ALJ stage of appeal from the QIC reconsideration stage of appeal, the ALJ is required to issue its decision “no later than the end of the 180 calendar day period beginning on the date that the request for escalation is received by the ALJ hearing office.”¹⁹

(2) In addition, the 90-day adjudication period is tolled if CMS or a CMS contractor participates in an ALJ hearing as a party, and a party requests discovery.²⁰

(3) If an appellant submits additional evidence not included with the request for ALJ hearing later than 10 calendar days after receiving the notice of hearing, “the period between the time the evidence was required to have been submitted and the time it is received is not counted toward the adjudication deadline...”²¹

(4) If an appellant fails to send a notice of its ALJ hearing request to the other parties, the 90-day adjudication period is tolled until all parties are notified of an appellant’s request for ALJ hearing.²²

(5) Although the CMS website indicates that a request for an in-person ALJ hearing will result in an extension of the 90-day adjudication timeframe (and accordingly, appellants should expect this result),²³ federal regulations explicitly state that “[w]hen a party’s request for an in-person hearing...is granted, the ALJ must issue a decision within the

adjudication timeframes specified in §405.1016...unless the party requesting the hearing agrees to waive such adjudication timeframe in writing.”²⁴

Stage 4

If a party is dissatisfied with an ALJ’s decision, it may file a request for Council review.²⁵ A request for Council review must be submitted within 60 days of the date of a party’s receipt of the ALJ decision (a party will be presumed to have received the ALJ decision five days after the date of the notice, unless there is evidence to the contrary).²⁶ The Council is required to conduct and conclude a review of the decision on an ALJ hearing and make a decision (or remand the case to the ALJ) in 90 days.²⁷ If the Council fails to issue its decision within this timeframe, a party may “escalate” its appeal to federal district court.²⁸

Stage 5

If a party is dissatisfied with the Council decision, it may file a request for federal district court review.²⁹ An amount in controversy requirement applies.³⁰

Effect of Failure to Adhere to Statutory, Regulatory and Sub-regulatory Guidelines

Appellants are held to strict adherence with the appeals timeframes summarized above. There are very limited exceptions, in cases where “good cause” is established. Examples of “good cause” for late filing as set forth in the regulations are limited to examples of serious illness, death, natural disaster, and circumstances beyond the control of the appellant.³¹ CMS sub-regulatory guidance makes clear that an appellant’s lack of administrative resources to enable it to meet its appeals deadlines is insufficient to establish good cause for late filing: “The contractor does not find good cause where the provider, physician, or other supplier claims that lack of business office

management skills or expertise caused late filing.”³²

On the other hand, citing their respective lack of administrative resources, the QICs, ALJs, and Council all have established a pattern and practice of failing to adhere to their respective adjudication timeframes, despite the clear statutory mandates. To date, and to great detriment to appellants, there has been no observable consequence to the review entities for failing to adhere to their respective adjudication timeframes.

Reconsideration Review

On December 5, 2013, the Part A QIC,³³ MAXIMUS Federal Services, Inc. (“Maximus”), reported that although it achieved nearly 100 percent compliance with the 60-day adjudication timeframe from 2009 through 2011, its compliance with this timeframe dropped to just 65 percent in 2012. The rationale given for the QIC’s failure to adhere to its mandatory adjudication timeframe was the increased volume of appeals submitted (e.g., with respect to Part A appeals, Maximus data reflects that less than 50,000 appeals were submitted in 2009, approximately 50,000 appeals were submitted in 2011 and nearly 300,000 appeals were submitted in 2013), as well as the nature of the appeals submitted (i.e., in 2009, approximately 50 percent of the appeals before this QIC were “technical” denials and 50 percent were based on medical record reviews. In 2013, approximately 90 percent of the appeals before this QIC were appeals of denials based on medical record reviews).

Maximus reported addressing its failure to comply with the adjudication timeframes by adding adjudication and operations staff, as well as by contracting with subcontractors approved by CMS. Based on these efforts, at least with respect to reconsideration reviews performed by Maximus, meeting adjudication timeframes has been largely restored. In

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November 2013, Maximus reported a return to 95 percent compliance with its 60-day adjudication mandate.³⁴

ALJ Hearing

As noted above, citing an “exponential growth in requests for hearing,” on December 24, 2013, OMHA Chief ALJ Griswold issued a “Memorandum to OMHA Medicare Appellants” advising of OMHA’s suspension of the assignment of new requests for ALJ hearing submitted by provider and supplier appellants, effective July 15, 2013.³⁵ By way of illustration with respect to OMHA’s hearing workload, Chief ALJ Griswold cited the following statistics: In January 2012, OMHA received an average of 1,250 appeals per week; in November 2013, OMHA received over 15,000 appeals per week (more than a 10-fold increase). Accordingly, in less than two years, OMHA’s pending appeals grew from under 92,000 to 460,000. At the time the Memorandum to OMHA Medicare Appellants was issued, OMHA had 357,000 claims in queue awaiting adjudication.

Although appellants must still abide by the statutory, regulatory and CMS sub-regulatory guidance related to timeframes for appeal, once OMHA receives an appeal, it will simply store the appeal for a period of time, without activity of any kind. The OMHA website projects a 20-24 week delay (*i.e.*, a 140-168 day delay) in docketing new requests for ALJ hearing.³⁶ Therefore, OMHA’s adjudication timeframe in most cases will have elapsed prior to an appeal even being docketed. OMHA has advised that as of January 24, 2014, there was an estimated delay of up to 28 months from the date a request for ALJ hearing was received until it will be assigned to an ALJ.³⁷ OMHA anticipates post-assignment hearing wait times to exceed six months.³⁸

Council Review

In addition, as part of an OMHA Medicare Appellant Forum held

February 12, 2014, the Chair of the Council, Judge Constance B. Tobias, noted that it was “unlikely” that the Council would meet the 90-day adjudication timeframe, given a steady increase in appeals submitted to the Council. As reported by Judge Tobias, “In FY 2013, the Council closed 2,592 appeals...the largest number in the history of the organization. By the end of FY 2013, the number of pending appeals was 4,888. This is 112% more than at the end of FY 2012.”³⁹

Detrimental Impact on Medicare Appellants Resulting from Adjudication Delays

Legal Implications

Unfortunately for appellants, there are significant (and what appear to be ignored) legal implications and financial repercussions for Medicare appellants resulting from the adjudicators’ respective failures to adhere to their statutory mandates for timely appeals adjudication. Significantly, delays in appeals processing not only violate the Social Security Act as summarized above, but also clearly result in a violation of appellants’ procedural due process rights, as appellants have been stripped of their statutory rights to timely appeals adjudication. In addition, adjudication delays have very real financial consequences for Medicare appellants.

Financial Repercussions

Recoupment

Of particular importance, the delay in appeals adjudication results in significant cash flow issues for appellants. While awaiting an ALJ hearing and decision, withholding of the monies allegedly owed will commence and the MAC will recoup the alleged overpayment. These cash flow interruptions can be particularly troublesome for smaller providers and suppliers faced with significant

overpayment demands resulting from post-payment audits. They are also problematic for larger providers and health and hospital systems.

Section 935(f)(2)(A) of the Medicare Prescription Drug, Improvement and Modernization Act (“MMA”) (Public Law 108-173) amended Section 1893 of the Social Security Act (42 U.S.C. § 1395ddd) to prohibit Medicare contractors from recouping an alleged overpayment until after a reconsideration decision is issued.⁴⁰ An alleged overpayment is not withheld or recouped during this time period, provided that expedited appeals timeframes are satisfied;⁴¹ however, interest accrues against the alleged overpayment.⁴² Following issuance of a partially favorable or unfavorable reconsideration decision, CMS will begin recoupment activities. As described in CMS sub-regulatory guidance:

During this appeal process, the Medicare contractor cannot recoup or demand the debt; however, the debt continues to age. Once both levels of appeal are completed and CMS prevails, collection activities, including demand letters and internal recoupment, may resume within the timeframes set forth.⁴³

Notably, appellants’ likelihood of success in the Medicare appeals process is greatest at the ALJ stage of appeal. A November 2012 Report by the Department of Health and Human Services’ Office of Inspector General (“OIG”) reported that the QICs issued fully favorable results in just 20 percent of cases decided at reconsideration.⁴⁴ In contrast, fully favorable ALJ decisions were issued in 56 percent of cases, and partially favorable ALJ decisions were issued in an additional six percent of cases.⁴⁵ The OIG reported variances in appeals results based on claim type and appellant, with Part A inpatient hospital appeals having the highest success rate, at 72 percent.⁴⁶ This percentage

is consistent with more recent data compiled by the American Hospital Association (“AHA”) as part of its RACTrac survey.⁴⁷ For healthcare provider and supplier appellants waiting years for an ALJ hearing to be held (and often several months thereafter for a decision to be issued), these appellants suffer the consequences of cash flow interruptions associated with CMS recoupment of an alleged overpayment, which ultimately may or may not be upheld at the ALJ stage of appeal.

Debt Collection

During the appeals process, CMS considers any alleged overpayment a “debt.” In many cases, the MAC will refer the debt to the Department of Treasury for collection efforts, even if an appeal is pending. The Debt Collection Improvement Act of 1996 (Public Law 104-134, April 26, 1996) (“DCIA”) governs referrals to the Department of Treasury for debt collection. Regulations codifying the DCIA are set forth at 31 C.F.R. § 285.12. Sub-regulatory guidance is set forth in the Medicare Financial Management Manual (CMS Internet-Only Publication 100-06), Chapter 4.

Under the DCIA, a creditor agency (*i.e.*, “any Federal agency that is owed a debt,” such as CMS) is required to transfer any debt that is more than 180 days delinquent to the Department of Treasury for collection efforts (a process referred to as “cross-servicing”).⁴⁸ For purposes of the DCIA, a “debt” includes “any amount of money, funds or property that has been determined by an appropriate official of the Federal government to be owed to the United States by a person,”⁴⁹ and includes Medicare overpayments. A debt is considered 180 days delinquent if more than 180 days have elapsed since the date of requested repayment set forth in the initial demand letter, “unless other satisfactory payment arrangements have been made,”⁵⁰ such as an extended repayment plan.⁵¹

Of particular significance, however, a debt is legally enforceable only if there has been a final agency determination with respect to the obligation.⁵² Arguably, no final agency determination has been made in situations where a provider or supplier disputes an overpayment determination and actively pursues an appeal. Indeed, the Medicare Financial Management Manual (CMS Internet-Only Publication 100-06), Chapter 4, Section 70.6 identifies overpayments “in appeal status (pending at any level)” as **debts ineligible for referral**. Despite this guidance, some MACs routinely refer debts to the Department of Treasury for cross-servicing even though an appeal is pending.⁵³ In many cases, after the Department of Treasury commences collection efforts, the MACs continue to recoup Medicare payments against the alleged overpayment, in essence resulting in a duplicate collection.⁵⁴ If this trend (of referral to the Department of Treasury for debt collection while an appeal is pending) continues, it will only add to the strain on an already over-burdened provider and supplier community.

Potential Resolutions

OMHA Initiatives

As part of the OMHA Appellant Forum held on February 12, 2014, OMHA noted that it had several initiatives planned that could help to resolve the backlog of appeals in queue for adjudication:

First, OMHA is considering the addition of a field office that will be located in the Central time zone. Adding adjudication resources to a new field office will help reduce processing time for appeals in queue. Of the existing four (4) OMHA field offices ((1) Irvine, California, (2) Cleveland, Ohio, (3) Arlington, Virginia and (4) Miami, Florida), three are located in the Eastern time zone. This has created challenges for OMHA to schedule ALJ hearings for appellants located across the nation.

Therefore, the addition of a field office located in the Central time zone should result in an easier (and therefore more expeditious) ALJ hearing scheduling process.⁵⁵

Additionally, OMHA is considering alternate adjudication models. Models being considered include OMHA-facilitated mediation and statistical sampling (during which an ALJ hearing would be held with respect to a sampling of appeals submitted with results extrapolated to other pending appeals).⁵⁶ OMHA is also considering engaging OMHA attorneys to review an ALJ hearing case file initially and “fast-track potentially favorable claims or narrow issues for hearing.”⁵⁷

During the OMHA Appellant Forum, a panel of ALJs also recommended that appellants consider waiving their right to hearing (*i.e.*, ask for an “on the record” decision) in an effort to expedite the decision-making process. The ALJs noted that scheduling hearings is often challenging and could result in a delay of the adjudication process.⁵⁸ Waiving the right to ALJ hearing may result in a slightly more expeditious ALJ decision being issued. However, by waiving the right to ALJ hearing, appellants place themselves at a disadvantage by waiving their first opportunity for oral argument.

Impact of Today’s Audit Landscape – Recovery Auditors

Over time, OMHA’s proposed initiatives will likely result in a resolution of the existing backlog of requests for ALJ hearing submitted. However, OMHA’s proposed initiatives do not address the cause for the backlog. Today’s audit environment is robust. Healthcare providers’ and suppliers’ Medicare claims are reviewed by numerous auditing bodies. Although OMHA cited the “[c]ontinuing expansion of all post-payment audit programs”⁵⁹ as one reason for the increase in appeals submitted, it is clear that the role of Recovery

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Auditors (formerly called Recovery Audit Contractors (“RACs”)) has been significant. In a report issued by the U.S. Government Accountability Office (“GAO”) on the topic, entitled “Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency,” the GAO found that Recovery Auditors conducted nearly five times as many medical reviews as Comprehensive Error Rate Testing (“CERT”) auditors, MACs and Zone Program Integrity Contractors (“ZPICs”) combined.⁶⁰

Significantly, Recovery Auditors are compensated on a contingency fee basis, receiving between 9 and 12.5 percent of alleged improper payments identified.⁶¹ Accordingly, Recovery Auditors are financially incented to request a high volume of records and find improper payments. Over the past few years, Recovery Auditors have focused ever-increasing medical review efforts on Part A inpatient hospital claims. CMS has increased the Additional Documentation Request (“ADR”) Limits imposed on Recovery Auditors over time,⁶² and the RACs have reported a correlated increase in collections.⁶³ By extension, OMHA has experienced an exponential growth in Part A claim appeals.⁶⁴ As noted above, hospitals have reported an approximate 70 percent success rate contesting Part A claim denials in the Medicare appeals process.⁶⁵ Given this data, as hospitals continue to receive Part A claim denials, they are likely to continue to appeal. The AHA has called on CMS⁶⁶ and Congress⁶⁷ to address issues associated with the ALJ backlog as tied to audit activities of the Recovery Auditors. Members of Congress also acknowledged the tie between the ALJ backlog and Recovery Audits, and recommended the following:

[W]e strongly recommend that CMS consider dedicating additional resources to help resolve OMHA’s backlog issue in order

for the claims appeal process to resume as usual. Furthermore, we strongly urge CMS to immediately reform the RAC process.⁶⁸

CMS recently has announced “pauses” in Recovery Audit activity, which will likely have the effect of reducing the overall number of claim denials and by extension the number of appeals submitted. As a result, OMHA will have the opportunity to adjudicate many of its pending appeals. These pauses in Recovery Audit activity include the following:

- On January 31, 2014, CMS announced an extension of its “probe and educate” medical review program.⁶⁹ The “probe and educate” program will cover inpatient claims with dates of admission between October 1, 2013 and September 30, 2014. During this time period, Recovery Auditors and Supplemental Medical Review Contractors (“SMRCs”) are prohibited from conducting medical reviews of hospital stays spanning 0-1 midnight for the purposes of determining whether admission to inpatient status was medically necessary. Recent legislation has prohibited Recovery Auditors from conducting patient status reviews with dates of admission October 1, 2013 through March 31, 2015.⁷⁰ MACs, rather than Recovery Auditors or SMRCs, will conduct pre-payment reviews of a limited sampling of inpatient hospital claims to determine whether the provisions of the 2014 Inpatient Prospective Payment System (“IPPS”) Final Rule were satisfied, including whether admission to inpatient status was medically necessary.⁷¹
- On February 18, 2014, CMS announced a pause in Recovery Audit activity in general while CMS is engaged in the procurement process for the next round of Recovery Audit contracts. CMS noted that it is “transition[ing] down” the current contracts so that

Recovery Auditors can complete all outstanding claim reviews by their respective contract end-dates. Important dates for this Recovery Audit pause include the following:

- February 21, 2014 was the final date a Recovery Auditor was permitted to send a post-payment ADR;
 - February 28, 2014 was the final date a MAC could send a pre-payment ADR for the Recovery Audit Prepayment Review Demonstration Program; and
 - June 1, 2014 was the final date a Recovery Auditor may send information regarding an unfavorable determination to a MAC for adjustment.⁷²
- Contemporaneous with its announcement of the “pause” in Recovery Audit activity, CMS also announced certain improvements to the Recovery Audit program generally, to be effective “with the next Recovery Audit Program awards.” One such improvement includes that CMS will require Recovery Auditors to adjust the ADR limit for providers based on their denial rate. That is, providers with low denial rates will have lower ADR limits than providers with high denial rates.⁷³ Ultimately, time will tell whether this “improvement” will have the effect of reducing Recovery Audit denials and by extension overall appeals submitted. This change may simply result in a redistribution of denials to certain providers, which may or may not affect the number of appeals submitted.

Potential Resolution through Litigation

Based on many of the issues outlined above, on May 22, 2014, the American Hospital Association (“AHA”), together with three plaintiff hospitals filed a complaint against Kathleen Sebelius in her official capacity as Secretary of Health and Human

Services.⁷⁴ The complaint requested a declaratory judgment that HHS' delay in Medicare appeals adjudication violates federal law, and further requested the court to issue the following orders:

1. That OMHA provide the plaintiff hospitals with an ALJ hearing and ALJ decision (as required by law) for all appeals pending at the ALJ level for 90 days or more;
2. That OMHA issue "the resolution required by law" for all of plaintiff hospitals' appeals pending at the ALJ level for 90 days or more; and
3. That "HHS otherwise comply with its statutory obligations in administering the appeals process for all hospitals."⁷⁵

Conclusion

The anticipated 2.5 year delay in ALJ appeals adjudication is untenable. Due process requires OMHA to find a way to meet its statutory obligation for timely appeals adjudication, and the financial viability of many healthcare providers and suppliers depends on a resolution to this extensive delay. This issue is not only at the forefront of OMHA's policy agenda, but also has captured the attention of CMS and members of Congress; therefore, some type of resolution is likely not far off. Healthcare attorneys representing providers and suppliers in the Medicare appeals process are well-advised to monitor OMHA's website for any announcements regarding implementation of new initiatives⁷⁶ as well as the CMS website for news regarding Recovery Audit activity,⁷⁷ as these areas are presently in flux.



Jessica Gustafson

Jessica L. Gustafson, Esq. and Abby Pendleton, Esq. are founding shareholders with the healthcare law firm of The Health Law Partners, P.C. The firm repre-

sents hospitals, physicians, and other healthcare providers and suppliers with respect to their healthcare legal needs. Ms. Gustafson and Ms. Pendleton co-lead



Abby Pendleton

the firm's Recovery Audit and Medicare appeals practice group, and specialize in a number of areas, including Medicare, Medicaid and other payor audit defense and appeals; healthcare regulatory matters; compliance; HIPAA privacy and security compliance matters; overpayment refunds; reimbursement and contracting matters; and payor de-participation matters. Ms. Gustafson can be reached at jgustafson@thehlp.com. Ms. Pendleton can be reached at apendleton@thehlp.com.

Endnotes

- 1 See Memorandum to OMHA Medicare Appellants issued December 24, 2013, available at www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf.
- 2 Medicare Claims Processing Manual ("MCPM") (CMS Pub. 100-04), Ch. 29, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 3 See Section 1869 (a) (2) of the Social Security Act (42 U.S.C. § 1395ff (a) (2)). See also 42 C.F.R. § 405.920 and MCPM (CMS Pub. 100-04), Ch. 29, § 200, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 4 Section 1869 (a) (3) (C) (i) of the Social Security Act (42 U.S.C. § 1395ff (a) (3) (C) (i)). See also 42 C.F.R. § 405.942 (a) and MCPM (CMS Pub. 100-04), Ch. 29, § 310.2, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 5 Section 1869 (a) (3) (C) (ii) of the Social Security Act (42 U.S.C. § 1395ff (a) (3) (C) (ii)). See also 42 C.F.R. § 405.950 and MCPM (CMS Pub. 100-04), Ch. 29, § 310.4, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 6 See Section 1869 (b) (1) of the Social Security Act (42 U.S.C. § 1395ff (b) (1)). See also 42 C.F.R. § 405.960 and MCPM (CMS Pub. 100-04), Ch. 29, § 320, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 7 See 42 C.F.R. § 405.964 and MCPM (CMS Pub. 100-04), Ch. 29, § 320.1, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 8 See Section 1869 (b) (1) (D) (i) of the Social Security Act (42 U.S.C. § 1395ff (b) (1) (D) (i)). See also 42 C.F.R. § 405.962 and MCPM (CMS Pub. 100-04), Ch. 29, § 320.2, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 9 42 C.F.R. § 405.966.
- 10 See Section 1869 (c) (3) (C) (i) of the Social Security Act (42 U.S.C. § 1395ff (c) (3) (C) (i)). See also 42 C.F.R. § 405.970 and MCPM (CMS Pub. 100-04), Ch. 29, § 320, available at

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.

- 11 See Section 1869 (c) (3) (C) (ii) of the Social Security Act (42 U.S.C. § 1395ff (c) (3) (C) (ii)). See also 42 C.F.R. § 405.970 (d) and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 12 See Section 1869 (b) (1) of the Social Security Act (42 U.S.C. § 1395ff (b) (1)). See also 42 C.F.R. § 405.1000 and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 13 See "Welcome and Update ALJ Hearing Process," included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
 - 14 42 C.F.R. § 405.1002 and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 15 See Section 1869 (b) (1) (E) of the Social Security Act (42 U.S.C. § 1395ff (b) (1) (E)). See also 42 C.F.R. § 405.1006 and MCPM (CMS Pub. 100-04), Ch. 29, § 330, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- For calendar year 2014, the amount in controversy must be at least \$140. See 78 Fed. Reg. 59702 (September 27, 2013) and www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ALJ.html.
- 16 See Section 1869 (d) (1) (A) of the Social Security Act (42 U.S.C. § 1395ff (d) (1) (A)) (emphasis added). See also 42 C.F.R. § 405.1016 and MCPM (CMS Pub. 100-04), Ch. 29, § 330.1, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- Certain limited exceptions to the 90-day adjudication time period are set forth in federal regulations and are further discussed in detail herein.
- 17 See Section 1869 (d) (3) (A) of the Social Security Act (42 U.S.C. § 1395ff (d) (3) (A)). See also 42 C.F.R. § 405.1104 and MCPM (CMS Pub. 100-04), Ch. 29, § 340, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 18 See notes 44 - 46.
 - 19 42 C.F.R. § 405.1016 (c).
 - 20 42 C.F.R. § 405.1016 (d).
 - 21 42 C.F.R. § 405.1018.
 - 22 42 C.F.R. § 405.1014 (b) (2).
 - 23 www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html.
 - 24 42 C.F.R. § 405.1020.
 - 25 See Section 1869 (b) (1) of the Social Security Act (42 U.S.C. § 1395ff (b) (1)). See also 42 C.F.R. § 405.1100 and MCPM (CMS Pub. 100-04), Ch. 29, § 340, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
 - 26 See 42 C.F.R. § 405.1102 and MCPM (CMS Pub. 100-04), Ch. 29, § 340, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.

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- www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 27 See Section 1869 (d) (2) (A) of the Social Security Act (42 U.S.C. § 1395ff (d) (2) (A)) and 42 C.F.R. § 405.1100.
- 28 See Section 1869 (d) (3) (B) of the Social Security Act (42 U.S.C. § 1395ff (d) (3) (B)) and 42 C.F.R. § 405.1132.
- 29 See Section 1869 (b) (1) of the Social Security Act (42 U.S.C. § 1395ff (b) (1)). See also 42 C.F.R. § 405.1136 and MCPM (CMS Pub. 100-04), Ch. 29, § 345, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 30 See Section 1869 (b) (1) (E) of the Social Security Act (42 U.S.C. § 1395ff (b) (1) (E)). See also 42 C.F.R. §§ 405.1006 (c) and 405.1136 (a), as well as MCPM (CMS Pub. 100-04), Ch. 29, § 340, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- For calendar year 2014, the amount in controversy threshold is \$1,430. See 78 Fed. Reg. 59702 (September 27, 2013) and www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html.
- 31 See 42 C.F.R. § 405.940 (b) (2). See also MCPM (CMS Pub. 100-04), Ch. 29, § 240 et seq., available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 32 MCPM (CMS Pub. 100-04), Ch. 29, § 240.3, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.
- 33 MAXIMUS Federal Services, Inc. presently serves as the Part A East and Part A West QIC. C2C Solutions, Inc. presently serves as the Part B North QIC and DME QIC. Q2 Administrators, LLC presently serves as the Part B South QIC. www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html.
- 34 See generally, “The View from the QIC,” presented by Janice H. Eidem, JD, PMP, CMS-QIC Lead, MAXIMUS Federal Services, Inc., to The National RAC Summit, December 5, 2013.
- 35 OMHA advised that it would continue to assign and process ALJ hearing requests submitted directly by Medicare beneficiaries. See Memorandum to OMHA Medicare Appellants issued December 24, 2013, available at www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf.
- 36 See www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.
- 37 See “Administrative Comments,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html. See also www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.
- 38 See www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html.
- 39 See “Departmental Appeals Board Update: Medicare Appeals Council,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
- 40 See also 42 C.F.R. § 405.379.
- 41 In order to avoid recoupment during the re-determination and reconsideration stages of review, an appellant must abide by expedited appeals timeframes. Specifically:
- A request for redetermination must be submitted within 40 days of the date of demand letter (rather than within 120 days); recoupment commences on day 41 if no appeal is filed. See MLN Matters Number MM 6183, available at <https://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf>.
 - A request for reconsideration must be submitted within 60 days of the date of redetermination decision (rather than within 180 days); recoupment may commence on day 61 if no appeal is filed. Of significance to appellants, this expedited timeframe could create challenges for those attempting to obtain additional documentation in support of an appeal to submit with the request for reconsideration. As noted elsewhere herein, federal regulations require all evidence to be submitted no later than the reconsideration stage of review. If an appellant fails to do so, absent good cause, new evidence may not be submitted at subsequent stages of appeal. See 42 C.F.R. § 405.966 and MLN Matters Number MM 6183, available at <https://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6183.pdf>.
- 42 See Medicare Financial Management Manual (“MFMM”) (CMS Pub. 100-06), Ch. 3 §200.6, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.
- Notably, in order to avoid assessment of interest to an alleged overpayment, many providers and suppliers have requested immediate offset of the alleged overpayment, resulting in immediate recoupment of the alleged overpayment. In these cases, the recoupment is considered “voluntary” and the appellant does not receive Section 935 interest if the overpayment is reversed as part of the appeals process. See <https://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7688.pdf>.
- 43 See MFMM (CMS Pub. 100-06), Ch. 3 §200, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.
- 44 OIG Report, “Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals” (OEI-02-10-00340) at p. 12, November 14, 2012, available at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.asp>.
- 45 *Id.*
- 46 *Id.*
- 47 As described by the AHA, “The American Hospital Association’s (AHA) RACTrac survey collects data from hospitals on a quarterly basis to assess the impact [of] the Medicare Recovery Audit Contractor (RAC) program on hospitals nationwide. AHA developed RACTrac in response to the lack of data and information provided by CMS on the impact of the RAC program on providers.” See www.aha.org/advocacy-issues/rac/ractrac.shtml.
- See Letter from Rick Pollack, Executive Vice President of the AHA, to Marilyn Tavener, Administrator of CMS, January 14, 2014, available at www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf.
- 48 31 C.F.R. § 285.12 (c).
- 49 31 C.F.R. § 285.12 (a).
- 50 31 C.F.R. § 285.12 (c) (3).
- 51 See MFMM (CMS Pub. 100-06), Ch. 4 §70.7, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf.
- 52 Federal regulations specifically note: “Where, for example, a debt is the subject of a pending administrative review process required by statute or regulation and collection action during the review process is prohibited, the debt is not considered legally enforceable...” *Id.* (emphasis added). Although recoupment is permitted following the reconsideration stage of review (and therefore this provision of the regulations is not directly relevant to the collection of Medicare overpayments), an argument can be made that no final agency determination exists with an alleged overpayment for which an appeal is pending. Therefore, referral to the Department of Treasury should not occur. Additionally, the MFMM (CMS Pub. 100-06), Ch. 4, § 70.6 further clarifies that overpayments or debts in appeal status are ineligible for referral to the Department of Treasury.
- 53 Numerous letters from contractors of the Department of Treasury demanding payment of an alleged overpayment associated with a post-payment Medicare audit appeal are on file with the authors.
- 54 Pursuant to the MFMM (CMS Pub. 100-06), Ch. 4, § 70.11:
- Once the debt is referred for cross servicing, active collection efforts by the Medicare contractors and/or CMS shall cease. **However, debt referred for cross servicing and/or TOP [Treasury Offset Program] shall still be maintained in the Medicare contractors’ internal systems for financial reporting, interest accrual, and possible internal recoupment.** Medicare contractors shall be responsible for updating all the applicable systems, including the DCS [Debt Collection System] for the change of the status and the balance of the debt.
- See www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf (emphasis added).
- The MFMM (CMS Pub. 100-06), Ch. 4 § 70.10 requires the following:
- Medicare contractors, at the time of input to DCS, shall determine IF the Non-MSP debt [Non-Medicare Secondary Payer debt] is currently being recouped through Medicare (claims payments/withhold), and if the anticipated recoupments shall collect the debt in full within three years. **If the contractor anticipates that the debt shall be collected in full within three years of delinquency by**

Medicare recoupment, the debt shall not be referred to a PCA [private collection agency] as part of the cross servicing collection process. A specific debt type has been established in the DCS for this purpose. The debt type shall alert Treasury that the debt is being recouped through Medicare and should not be forwarded to a PCA. This determination shall eliminate many duplicate collections...

Therefore, pursuant to the sub-regulatory guidance cited above, if a MAC does not anticipate that recoupment will result in full collection within three years, it is authorized to refer to the debt to the Department of Treasury for cross-servicing. See www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf (emphasis added).

- 55 See “Welcome and Update ALJ Hearing Process,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
- 56 See “Policy Update,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
- 57 *Id.*
- 58 See “The Administrative Hearing – Appellant Do’s and Don’ts,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
- 59 See “Welcome and Update ALJ Hearing Process,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html (emphasis added).
- 60 CMS has adopted and implemented numerous Medicare auditing initiatives, each with a slightly different focus:
 - CERT audits measure improper payments in the Medicare fee-for-service (“FFS”) program, in an attempt to establish a nationwide Medicare FFS improper payment rate. www.cms.gov/CERT.
 - MACs are tasked to “process and pay claims and are responsible for taking actions to reduce payment errors in their jurisdictions.” See Executive Summary available at www.gao.gov/assets/660/656133.pdf.
 - Recovery Auditors are private companies that have contracted with CMS and that are tasked to identify and correct improper payments in the Medicare and Medicaid programs. See www.cms.gov/RAC.
 - Zone Program Integrity Contractor (“ZPIC”) auditors are tasked to investigate potential fraud. ZPIC audits may result in referrals to law enforcement or administrative actions. See Executive Summary available at www.gao.gov/assets/660/656133.pdf.
 - Supplemental Medical Review Contractor (“SMRC”) audits are the newest player in the Medicare auditing arena. StrategicHealth Solutions, LLC has secured a five year contract with CMS to serve as the SMRC auditor, tasked to “perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid Programs.” See www.strategichs.com/about-smrc.
- 61 See Solicitation Number RFP-CMS-2007-0022 (October 3, 2008), <https://fbo.gov/index>

?s=opportunity&mode=form&id=5c8c7d4b00249ba579d4d77d64bd0aea&tab=core&_cview=1&cck=1&au=&cck=.

- 62 The maximum number of requests per 45 days effective November 2, 2010 was 300. See www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-AuditProgram/Downloads/ADRLimits2.pdf.
On March 15, 2012, the maximum number of requests per 45 days increased to 400. See www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-AuditProgram/Downloads/Providers_ADRLimit_Update-03-12.pdf.
However, providers with over \$100 million in MS-DRG payments will have a cap of 600. See www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-AuditProgram/Downloads/April-2013-Provider-ADR-Limit-Update1.pdf.
- 63 In the 4th Quarter of 2012, CMS reported that the Recovery Auditors fiscal year (“FY”) to date corrections totaled over \$2.4 billion. Part A inpatient hospital claims were the “top issue” audited in each Recovery Audit region. See Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter (4th Quarter 2012), available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-4th-Qtr-2012.pdf.
In the 4th Quarter of 2013, CMS reported that the Recovery Auditors FY to date corrections totaled over \$3.8 billion. Part A inpatient hospital claims remained the “top issue” audited nationwide. See Medicare Fee for Service National Recovery Audit Program Quarterly Newsletter (4th Quarter 2013), available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-4th-Qtr-2013.pdf.
- 64 OMHA reported receiving approximately 50,000 Part A claim appeals in FY 2012 and approximately 225,000 Part A claim appeals in FY 2013. See “Welcome and Update ALJ Hearing Process,” included as part of the OMHA Medicare Appellant Forum Presentations, available at www.hhs.gov/omha/omha_medicare_appellant_forum.html.
- 65 See Letter from Rick Pollack, Executive Vice President of the AHA, to Marilyn Tavenner, Administrator of CMS, January 14, 2014, available at www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf.
- 66 *Id.*
- 67 See Letter from Rick Pollack, Executive Vice President of the AHA, to Member of Congress, dated January 14, 2014, available at www.aha.org/advocacy-issues/letter/2014/140114-pollack-congress-rac.pdf.
- 68 See Letter from Members of Congress to Kathleen Sebelius, Secretary of HHS, dated February 10, 2014, available at www.aha.org/content/14/140210-let-congress-hhs.pdf.
- 69 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.
On August 2, 2013, the Centers for Medicare

& Medicaid Services (“CMS”) released its 2014 Inpatient Prospective Payment System (“IPPS”) Final Rule (the “Final Rule”), which became effective on October 1, 2013. 78 Fed. Reg. 50496 *et seq.* (August 19, 2013) available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html?DLPage=1&DLSort=0&DLSortDir=ascending>.

The Final Rule revised CMS’s reimbursement criteria for Part A inpatient hospital claims, creating new guidelines to establish the medical necessity of inpatient hospital admissions (i.e., establishing the “2-midnight rule”) and clarifying CMS’ documentation requirements related to physician inpatient admission orders and certifications. Following implementation of the Final Rule, CMS created a medical review program, known as the “probe and educate” medical review program, designed to provide education to hospitals implementing the requirements of the Final Rule. Before its extension, the “probe and educate” program was initially planned to cover Medicare Part A inpatient hospital claims with dates of service between October 1, 2013 and March 31, 2014. During this time, recovery auditors and Supplemental Medical Review Contractors (“SMRCs”) would be prohibited from conducting post-payment reviews of Medicare Part A inpatient hospital claims crossing 0-1 midnights for the purpose of determining whether inpatient “status” was appropriate. See www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

- 70 Section 111 of the Protecting Access to Medicare Act of 2014 (H.R. 4302) permits the extension of the probe and educate medical review program through March 31, 2015, and prohibits Recovery Auditors from performing patient “status” reviews for inpatient claims with dates of admission October 1, 2013 through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse or delays in the provision of care. See www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf.
- 71 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/SelectingHospitalClaimsForAdmissionsForPosting02242014.pdf>.
- 72 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html.
- 73 See RAC Program Improvements, available at www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.
- 74 Civil Action No. 14-cv-851, filed May 22, 2014, available at www.aha.org/content/14/140522complaint-appeals.pdf.
- 75 *Id.*
- 76 www.hhs.gov/omha/index.html.
- 77 www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program.