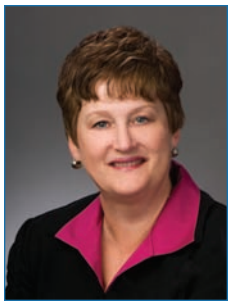

LEGAL ISSUES

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The Medicare Appeals Process: An Extreme Backlog

Payments to health care providers under the Medicare program are subject to potential repayment or recoupment via the review processes that protect the fiscal integrity of the Medicare program. When the review process demands repayment from a provider for Medicare Part A or Part B claims, a multistage, uniform Medicare Part A and Part B process allows that provider to appeal the decision. However, providers have a long wait — ranging from many months to several years — before their appeals will be adjudicated through the system. Recent public scrutiny has highlighted the significant delays that are creating hardship during this lengthy appeal process.

The appeal process established by the Social Security Act consists of five levels, each with various timelines to which the appellant and the adjudicating body must adhere for requesting the appeal and issuing a decision.

- Level 1: Redetermination by a Medicare Administrative Contractor (MAC);
- Level 2: Reconsideration by a Qualified Independent Contractor (QIC);
- Level 3: Hearing before an Administrative Law Judge (ALJ);
- Level 4: Review by the Medicare Appeals Council; and
- Level 5: Judicial review in a U.S. District Court.

Levels three and four of the appeals process — a hearing before an ALJ, and review by the Appeals Council — are currently experiencing extreme backlogs. This backlog has serious financial implications for Medicare beneficiaries and providers. For a health care provider, such as a physician or nursing facility, determined overpayments are recouped pending the final appeal outcome, and interest runs on the overpayments beginning 30 days after the initial demand for recoupment of an overpayment.

The Office of Medicare Hearings and Appeals (OMHA), an agency within the Department of Health and Human Services (HHS), oversees ALJ hearings for providers and beneficiaries at the third level in the appeals process. The Departmental Appeals Board oversees the Appeals Council on the fourth level of the process. The Act specifies that a decision should be issued by the ALJ and by the Appeals Council within 90 days after a requested hearing at each level. However, as of October 2016, decisions at the ALJ level were being issued, on average, around 935.4 days after a hearing was requested — more than 10 times longer than provided for by the Act. At the end of the 2015 fiscal year, 14,000 appeals were pending with the Appeals Council.

One skilled nursing facility's experience in the appeals process demonstrates the impact of this delay. The facility began the appeals process in the first quarter of 2012 by filing Requests for Redetermination for various claims in level one of the appeals process. The multiple claims for the provider were eventually consolidated, and the provider appealed to the ALJ in level three of the process in the first quarter of 2015. As of press time, almost 2 years after the facility filed for an appeal to the ALJ, an ALJ has yet to be assigned. The appeals process at this level is stalled.

During its first quarterly report to the court, HHS made clear that it will not be able to meet the court's imposed deadline of eliminating the backlog of appeals without additional resources and funding.

Enormous Backlog

HHS has identified several factors leading to this enormous backlog. More baby boomers are reaching age 65, making them eligible for Medicare benefits. People are living longer, and more disabled individuals are enrolling in Medicare. Additionally, the increase in Medicare beneficiaries has not been met with an increase in funding for the appeals process, so the same resources are being used to meet a greater demand for appeals, which have increased by 442% over 5 years at the ALJ level and by 2,000% over 6 years at the Appeals Council level.

To alleviate this backlog, HHS has implemented several administrative actions, including creating an administrative settlement process, facilitating settlement conferences, instituting a prior authorization process for certain services and devices, and more. These actions are likely to reduce the backlog to about 1 million appeals by 2020 — less than half the amount of pending appeals projected to exist without any sort of administrative action being implemented. HHS, however, believes it can do more to completely eliminate the backlog by 2021 by adopting a three-pronged strategy:

1. Investing new resources across all levels of the appeals process to increase adjudication capacity, and implementing new strategies to alleviate the backlog;
2. Taking administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and
3. Proposing legislative reforms that provide additional funding and new authorities to address the appeals volume.

HHS also issued a final rule in early January 2017 that makes several changes to the appeals process, including permitting appeals to be heard by attorney adjudicators rather than ALJs at the ALJ level, and allowing precedential decision making at the Appeals Council level.

Incremental Reductions

Recently, in a case brought by the American Hospital Association as a result of frustration with the delays in the appeals process, a federal district court agreed that more could and should be done to eliminate the tremendous backlog. The court ordered HHS to make incremental reductions in the backlog until it is eliminated over the span of 4 years. Specifically, the backlog must be reduced 30% by the end of 2017, 60% by the end of 2018, 90% by the end of 2019, and completely by the end of 2020. To ensure that HHS is complying with these requirements, it must submit progress reports to the court quarterly that show the reduction in backlog along with updated projections for further reduction and a description of significant legislative and administrative actions that will impact the backlog.

Although each of these efforts is intended to reduce and eventually eliminate the backlog — which suggests that providers and beneficiaries can expect the appeals process to begin flowing more quickly — those going through the appeals process should remain prepared for the process to continue to move at an exponentially slow rate. During its first quarterly report to the court, HHS made clear that it will not be able to meet the court's imposed deadline of eliminating the backlog of appeals without additional resources and funding. According to HHS, OMHA can hear only about 76,000 appeals each year based on its current staffing — just one of the issues affecting the agency's ability to reduce the backlog. Further, because the district court decision impacts only the ALJ level, it's unclear how much the administrative actions implemented by HHS will reduce the backlog at the Appeals Council level; that is, if they are not reduced at the same rate that the ALJ appeals are reduced, the result will be an increased backlog and further delays at the Appeals Council level.

Be Prepared

Even during this period of backlog, providers can reduce their likelihood of being caught in the appeals quagmire. As the complex, delayed appeal process continues, HHS or other agencies or courts may develop other solutions to clear the backlog and administer the process in a timely manner. Providers also can help expedite the process: when a review occurs for potential overpayments, the auditors will request various pieces of information from the provider, so providers should be prepared and supply their supporting documentation in a timely manner. Additionally, when it is available, providers should use the preapproval process for claims to ensure that their claims are appropriately authorized before they're submitted for payment — these processes allow providers to efficiently demonstrate throughout the appeals process that they are entitled to the disputed Medicare payments. This may allow a case to be resolved before it reaches the ALJ level, thus avoiding the backlog altogether.

Those going through the appeals process should remain prepared for the process to move at an exponentially slow rate.

As always, good documentation to support the need for and delivery of Medicare goods or services is important. Also, accurate, timely billing with adherence to all the requirements supports a clean claims process.

This column is not to be substituted for legal advice. Ms. Feldkamp practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, OH. Special thanks to Victoria Stephenson of Benesch for her assistance with this column.