



Medicare Appeals Process: Is the End of the Deadlock Anywhere In Sight and What Relief Is Available?

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The past decade has witnessed a significant increase in methods by which the Centers for Medicare and Medicaid Services (CMS) has attempted to identify fraud, waste, and abuse in the federal health care system. These initiatives include prospective review efforts to identify submitted claims that are not eligible for payment and retrospective reviews of paid claims that a subsequent analysis determined were improperly paid.¹ The Department of Health and Human Services (HHS) has promulgated regulations establishing an appeal process that historically was sufficient to timely process the appeals of adverse determinations. However, the current mandated process is not sufficient in light of the increase in Medicare claims filed and corresponding enforcement efforts. The inability of CMS to meet its mandated processing times puts those appealing providers in a precarious financial position. Unlike some other types of administrative appeals where appealing may delay enforcement of a negative determination until its appeals are exhausted, CMS may begin recouping monies paid to providers at the third of the five levels of appeal at what is commonly known as the Administrative Law Judge (ALJ) Level.

The backlog at the ALJ Level has caused providers to seek relief from the courts to overcome the inadequacies of the current appeals process.² Simultaneous with such litigation, CMS finalized changes in 2017 and 2018 to the Medicare appeals process, in particular at the ALJ level, to address the backlog. This article will examine the Medicare appeals process, the backlog that has resulted, and the litigation efforts by those impacted providers and suppliers to bypass the process or, at a minimum, seek relief due to CMS not being able to meet the mandated time for processing the appeals.

Medicare Appeals Process

CMS administers the Medicare program through promulgated rules and policies that dictate conditions of participation and coverage and payment requirements. CMS contracts with Medicare Administrative Contractors (MACs) who are private third parties contracted with on a geographic regional basis to handle the oversight of Medicare Part A and B medical claims or durable medical equipment claims for Medicare Fee-for-Service (FFS) beneficiaries. These functions include enrolling providers, reviewing submitted claims, and making the initial determination of whether claims should be paid, processing the payments, educating enrolled providers and suppliers and responding to their inquiries, and handling redetermination requests for claims that have been denied.³

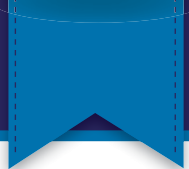
A participating provider or supplier, Medicare beneficiary, or a non-participating provider or supplier who has been assigned the claim by the Medicare beneficiary may appeal an adverse initial determination.⁴ The appeals process for Part A and B medical claims or durable medical equipment claims is a five-level process.⁵ These five levels are as follows:⁶

- First Level of Appeal: Redetermination by a Medicare Administrative Contractor (MAC)
- Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)
- Third Level of Appeal: Decision by the Office of Medicare Hearings and Appeals (OMHA) that administers the hearing process before the ALJ
- Fourth Level of Appeal: Review by the Medicare Appeals Council that is administered by the Departmental Appeals Board (DAB)
- Fifth Level of Appeal: Judicial Review in Federal District Court

OMHA operates separate from CMS and the DAB operates separate from CMS and OMHA.

The First Level of Appeal,⁷ or the redetermination, must be submitted to the MAC in writing within 120 days from the date of receipt of the initial determination of the claim. The redetermination request must include the appellant's name, the identification of a representative if one has been appointed, all pertinent information necessary for a determination of the appeal, and must be signed by the individual submitting it. There is no minimum amount in controversy at this Level. While the redetermination is conducted by the MAC who made the initial determination, separate staff who were not involved with the initial determination will review and render the redetermination decision.⁸ A timely filed redetermination request may delay recoupment of any monies paid on the claims that are the subject of the appeal.

In the event the appellant receives an adverse determination through redetermination, an appeal to the Second Level⁹ to the QIC, referred to as reconsideration, is available. There is no minimum amount in controversy for this level. The reconsideration request must be submitted in writing within 180 days of the receipt of the notice of the redetermination decision setting forth



the basis of the appellant's disagreement with the redetermination decision. The QIC will conduct an independent review of the information submitted including the redetermination decision. Any documentation noted missing in the redetermination decision or which will be relevant or otherwise support your position should be provided at this time. If not, it may be excluded from subsequent levels of appeal unless the appellant can demonstrate good cause as to why it was not submitted at this level. A decision is usually rendered within 60 days of the receipt of the reconsideration request. However, where the QIC is unable to make a decision during this time period, it will notify the appellant of the possibility of the delay and provide the process whereby the appeal may be made to the Third Level at the OMHA.¹⁰ A timely filed reconsideration request may delay recoupment of any monies paid on the claims that are the subject of the appeal.

Appellant may appeal an adverse reconsideration decision to the Third Level of Appeal,¹¹ administered by OMHA, that is commonly referred to as the ALJ Level. This level is where the bottleneck has occurred in the Medicare appeals process. A request for an ALJ hearing, or a waiver of hearing, must be submitted within 60 days of the appellant receiving the reconsideration decision letter or the filing of a request with the QIC for OMHA review after the expiration of the reconsideration period. The appeal before the ALJ will either be telephonic, via video conference or, in the rare instance where good cause is demonstrated, an in-person hearing. OMHA provides for the bypass of a hearing before an ALJ by offering a consideration of the appeal through an OMHA ALJ Adjudicator (Attorney Adjudicator). This process allows for the appeal to be determined upon the evidence submitted and the administrative record. There is a minimum amount in controversy, that is periodically adjusted, that must be met to proceed to this Level. The amount in controversy for 2018 and 2019 is \$160. The concerns arising from the bottleneck is that unlike the first two Levels recoupment activities may begin after the reconsideration decision is rendered. The ability of CMS to recoup monies that still have three levels of appeal available may put the appellant in a precarious financial position. As previously mentioned, the delay in being able to exercise the right to a hearing before an ALJ is not just in days, weeks, or months but now years. As of the last review by CMS on August 28, 2018, the average processing time is 1,142 days, or more than three years and one month's time. The adverse effects of this delay can be compounded when the recoupment is based upon an adverse finding of a statistical sample set of claims that is then extrapolated over a large population. If a timely response at this level is not received, the appellant may file for an expedited appeal to the Medicare Appeals Council (Council).

The Council is the Fourth Level of Appeal. This appeal must be filed within 60 days of receipt of the ALJ's decision or after the OMHA decision timeframe expires. There is no minimum amount in controversy for Council review. Because of the backlog at the ALJ Level, the Council is experiencing a greater amount of appeals than historically seen due to the increased number of appeals and the right to escalate the appeal to this level if an

appeal is not timely processed at the Third Level. The Council will review the information presented and the arguments submitted that forms and will make a decision. If the mandated time-frame for a decision is not met, the appellant may proceed to the last level of appeal, which is a judicial review.

The Fifth Level of Appeal¹² is a judicial review by a federal district court. An appeal to this level is available as the appeal of last resort if the appellant receives an adverse ruling from the Council. Also, an appeal to the Fifth Level is available in the event the Council fails to issue a decision or does not remand the case to an ALJ or Attorney Adjudicator within the required adjudication period. The request for judicial review must be filed within 60 days of receipt of the Fourth Level decision or after the Council ruling timeframe expires. This level does have a minimum amount in controversy, similar to the ALJ Level, currently at \$160 for 2018 and 2019, that is periodically adjusted.

CMS Initiatives to Improve the Medicare Appeals Process

CMS has recognized the need to facilitate faster processing of Medicare appeals at the OMHA and Council Levels. One method of accomplishing this goal is to offer additional settlement options for those with claims pending at the two levels. The first remedy is to offer the low volume appeals settlement option (LVA). This option is limited to appellants with fewer than 500 Medicare Part A or Part B claim appeals pending at OMHA and the Council, combined, as of November 3, 2017, with a total billed amount of \$9,000 or less per appeal as long as certain conditions are met. CMS is willing to settle appeals eligible for LVA at 62% of the net allowed amount.¹³ Additionally, OMHA has expanded the Settlement Conference Facilitation Process to allow CMS and appellants an opportunity to reach a mutually agreeable resolution of the Medicare appeals. This alternative dispute resolution utilizes a mediation process to attempt to reach an amicable settlement.¹⁴

Litigation Arising Out of the Medicare Appeal Backlog

The backlog of processing Medicare appeals at the Third and Fourth Levels has caused providers and suppliers to seek alternative relief from the Medicare appeals process or at a minimum, stop recoupment during their appeal. The Medicare Act requires that all administrative appeals—in other words, the first four levels—be exhausted prior to the federal courts having jurisdiction to address such claims.¹⁵ Three recent cases are currently pending that impact the backlog and have provided relief to providers and suppliers.

The first case was initiated in 2014 by the American Hospital Association (AHA). AHA filed a mandamus action against the Secretary of HHS to compel the processing of Medicare appeals pursuant to the statutory timeline to clear the appeals at OMHA. The district court granted the Secretary's motion to dismiss citing the efforts of HHS to resolve the situation and recognizing its budgetary restraints.¹⁶ On appeal, the D.C. Circuit instructed the district court to weigh the equities in determining whether the issuing of mandamus was proper.¹⁷ The case has subsequently

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bounced from the district court to the D.C. Circuit on multiple occasions. On remand, the district court found that HHS' efforts were unlikely to resolve the backlog and concluded equities dictated a ruling in favor of the providers.¹⁸ The district court ordered the Secretary to set a time-table for clearing the backlog. The Secretary appealed this ruling on the basis that meeting the targets set by the district court would be impossible to meet absent *en masse* settling of claims that would be contrary to the Medicare Statute. The D.C. Circuit found that the district court erred in not considering the Secretary's position that it would be impossible to meet the targets without violating the Medicare Statute.¹⁹ The D.C. Circuit remanded back to district court to consider the Secretary's argument that lawful compliance was impossible in crafting further orders.²⁰ Finally, on November 1, 2018, after years of litigation, the district court ordered HHS to clear the backlog within four years after HHS acknowledged that such would be possible in light of recent funding appropriated to address the issue.²¹

While *AHA v. Price* has not currently provided any relief to the Medicare appeals crisis, *Family Rehab. Inc. v. Azar*²² did provide some recourse for those in dire need of action. Family Rehabilitation, a home health provider, was assessed with a \$7,622,122.31 overpayment and proceeded through the first two levels of appeal without success. When the matter proceeded to the Third Level, CMS initiated recoupment on the amounts allegedly owed. Family Rehabilitation sued in U.S. district court to enjoin CMS from recouping the money, alleging that recoupment would cause the company to go bankrupt. The district court initially dismissed the suit, finding no subject matter jurisdiction for failing to exhaust administrative remedies. Family Rehabilitation appealed to the Fifth Circuit, which reversed and remanded. The Fifth Circuit determined that the claims were collateral to substantive agency decision.²³ Further, the appeals court ruled that Family Rehabilitation had raised a colorable claim that erroneous recoupment would cause irreparable damage.²⁴ After remand, the district court granted a temporary restraining order (TRO) to prevent the recoupment.²⁵ After a hearing for the TRO, the district court also found that Family Rehabilitation had a high risk of an erroneous deprivation of its property interest due to the extreme backlog of cases before the ALJ, which constituted a substantial threat of irreparable injury from the recoupment. The court indicated that Family Rehabilitation has a substantial likelihood of success on the merits of its procedural due process claim because of the backlog.

Another case that provided some relief from recoupment during the Medicare appeals bottleneck is *Adams EMS, Inc. v. Azar*. Adams is an ambulance company that was appealing an adverse determination resulting in an alleged \$418,035 overpayment. The U.S. district court granted Adams' request for a TRO suspending recoupment based upon HHS failing to provide procedures for, and timely adjudicate, administrative relief for the overpayment ruling and subsequent recoupment action.²⁶ On October 23, 2018, the court denied the government's motion to dismiss for lack of subject matter jurisdiction and granted Adams' motion for temporary injunction to enjoin the government from withholding any monies due from Adams' Medicare receivables.²⁷ The court

held that Adams had pled sufficient facts to demonstrate a clear right to relief and that the harm to HHS is minimal if the temporary injunction was granted compared to the level of harm that would be suffered by Adams if it was not granted. The court also ruled that it is in public interest to grant the preliminary injunction because Adams' patients, and others in need of ambulance services in Adams' service area, would be harmed if Adams filed for bankruptcy and ceased operations. The court relied heavily on *Family Rehabilitation* in granting both the temporary restraining order and preliminary injunction.

However, a week after the *Adams EMS* decision, a U.S. district court in Ohio denied the request of a home health company for a temporary restraining order prohibiting the recoupment of alleged overpayments until the ALJ had rendered its decision. The court in *PHHC, LLC v. Azar*, ruled that the home health company could not pursue due process claims related to the recoupment because it was not able to demonstrate a property or liberty interest in the alleged overpayment amounts. The court denied the motion for temporary restraining order and granted the government's motion to dismiss.²⁸

Conclusion

The Medicare appeals process is a multistep process that was sufficient to timely handle appeals until the expanded audit and review efforts of Medicare claims resulted in an increase in filings for relief from adverse determinations. While HHS has implemented certain initiatives to reduce the backlog, the average time to process an appeal at the ALJ Level is now more than three years. Since HHS may begin recoupment at this level, the delay in processing appeals according to the mandated time periods may put a Medicare provider or supplier in serious financial jeopardy. Historically, the courts have not granted relief during the appeals process since one must exhaust their appeals before seeking judicial redress. However, recent court decisions have demonstrated that the judiciary is now willing to address the Medicare appeals backlog and grant relief to those who will suffer irreparable harm due to the failure of the system allowing them to exercise the appeals rights that they are entitled. This relief is not absolute, however, as court challenges have reached differing conclusions.

- 1 The primary auditors contracted with CMS to perform these reviews are Recovery Audit Contractors and Zone Program Integrity Contractors, referred to as RAC and ZPIC auditors, respectively.
- 2 According to CMS, the average process time at the ALJ Level has increased in the past ten years from 94.9 days in Fiscal Year 2009 to 1,142 days through 1,142 days during the third quarter of Fiscal Year 2018. CMS, *Average Processing Time by Fiscal Year*, available at <https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html>.
- 3 *What is a MAC*, CMS, available at <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html>.
- 4 42 C.F.R. 405.906, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7961d28344484cd4a105147950468422&ty=HTML&h=L&n=42y2.0.1.2.5.8&r=SUBPART#se42.2.405_1906.

- 5 For certain Part A services reimbursed through the filing of a cost report, an appeal may be through a Contractor Hearing Officer if the amount in controversy is at least \$1,000 and less than \$10,000. If the amount in controversy is \$10,000 or more, a provider can receive a hearing before the Medicare Provider Reimbursement Review Board (PRRB). See 42 C.F.R. §§ 405.1835 – 405.1889, available at <https://www.gpo.gov/fdsys/pkg/CFR-2004-title42-vol2/pdf/CFR-2004-title42-vol2-part405-subpartR.pdf>.
- 6 *Original Medicare (Fee-for-service) Appeals*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html>.
- 7 *First Level of Appeal: Redetermination by a Medicare Contractor*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html>.
- 8 See 42 CFR §§405.940 – 405.958, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7961d28344484cd4a105147950468422&ty=HTML&h=L&n=42y2.0.1.2.5.8&r=SUBPART#se42.2.405_1960.
- 9 *Second Level of Appeal: Reconsideration by a Qualified Independent Contractor*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html>.
- 10 See 42 CFR §§405.960 – 405.978, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=7961d28344484cd4a105147950468422&ty=HTML&h=L&n=42y2.0.1.2.5.8&r=SUBPART#se42.2.405_1960.
- 11 *Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals (OMHA)*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing.html>.
- 12 *Fifth Level of Appeal: Judicial Review in Federal District Court*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html>.
- 13 See *Original Medicare (Fee-for-service) Appeals, What's New*, CMS, available at <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html>.
- 14 *Settlement Conference Facilitation*, CMS, available at <https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html>.
- 15 See 42 U.S.C. §405(g) and (h), made applicable to Medicare according to 42 U.S.C. §1395ff(b)(1)A).
- 16 *Amer. Hosp. Ass'n v. Burwell*, 76 F.Supp.3d 43 (D.C.C. 2014).
- 17 *Amer. Hosp. Ass'n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016).
- 18 *Amer. Hosp. Ass'n v. Burwell*, No. 14-851, WL 7076983 (D.C.C. 2016).
- 19 *Amer. Hosp. Ass'n v. Price, f/n/a Amer. Hosp. Ass'n v. Burwell*, 867 F.3d 160, 166 (D.C. Cir. 2017).
- 20 867 F.3d at 170.
- 21 *Amer. Hosp. Ass'n v. Azar, f/n/a Amer. Hosp. Ass'n v. Price*, No. 14-851, 2018 WL 5723141 (D.C.C. 2018).
- 22 886 F.3d 496 (5th Cir. 2018).
- 23 886 F.3d at 501-504.
- 24 *Id.* at 504.
- 25 *Family Rehab, Inc. v. Azar*, No. 17-3008, 2018 WL 2670730 (N.D. Tex. June 4, 2018).
- 26 *Adams EMS, Inc. v. Azar*, No. 18-1443, 2018 WL 3377787 (S.D. Tex., July 11, 2018).
- 27 *Adams EMS, Inc. v. Azar*, No. 18-1443, 2018 WL 5264244 (S.D. Tex., Oct. 23, 2018).
- 28 *PHHC, Inc. v. Azar*, No. 18CV1824, 2018 WL 5754393 (N.D. Ohio, Nov. 2, 2018).

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