OMHA's Medicare Appellant Forum Offers Few Meaningful Answers for Frustrated Medicare Providers and Suppliers

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On February 12, 2014, the Office of Medicare Hearings and Appeals (**"OMHA"**) hosted a Medicare Appellant Forum ("Forum") to address its current backlog of appeals. OMHA is responsible for hearings before Administrative Law Judges ("**ALJs**") on a range of Medicare appeals, which is the third level of appeals in the Medicare administrative appeals process. Providers and suppliers of Medicare services and products have voiced frustration with the appeals backlog, particularly because many believe that this is the first level of the appeals process where meaningful relief can be obtained. Unfortunately, the Forum offered few assurances to providers and suppliers of Medicare services and products that any effective remedies to the delays in the appeals process will be implemented in the near term.

During the Forum, OMHA described various reactive measures being taken to manage its increased caseload. However, OMHA representatives failed to address two critical issues in any meaningful way: first, OMHA representatives could not provide a legal justification for OMHA's newly adopted policy of deferring assignments of new and pending appeals, which is expected to last up to two years; second, OMHA representatives did not explain how OMHA's caseload could be improved if the Centers for Medicare & Medicaid Services ("**CMS**") were to implement remedies at the first two levels of the Medicare appeals process.

Highlights from the Forum

The OMHA forum was convened by OMHA's Chief ALJ, Nancy Griswold, who sent a letter to Medicare appellants in December 2013 announcing that, due to the agency's caseload, it was "temporarily suspend[ing] the assignment of most new requests for an Administrative Law Judge hearing to allow OMHA to adjudicate appeals involving

almost 357,000 claims for Medicare services and entitlements already assigned to its 65 Administrative Law Judges."[1]

Judge Griswold framed the Forum as an opportunity to promote an environment of transparency. She stated that OMHA was not seeking to "artificially limit the number of appeals" nor impose a "moratorium" on hearings, but to "manage [OMHA's] caseload" by implementing a "deferred case assignment policy." This policy has resulted in 480,000 filed appeals currently being held at OMHA's National Request for Hearing Processing Center in Cleveland, Ohio, awaiting assignment to an ALJ. According to OMHA, as of February 23, 2014, the estimated delay until a hearing is assigned to a specific ALJ's docket is up to **28 months**; the estimated average wait time to obtain a hearing after assignment exceeds **six months**.

OMHA attributes these delays to the unexpected rise in the volume of appeals to the ALJ level since 2012. In the aggregate, ALJ hearing requests increased from 1,250 filings per week in January 2012 to 15,000 per week in January 2014. Judge Griswold identified three reasons for this increase:

(1) an increasing number of Medicare beneficiaries;

(2) an increase in OMHA's dual-eligible workload as state Medicaid agencies become more active; and

(3) expansion of post-payment audits, such as Recovery Audit Contractor ("**RAC**") and Zone Program Integrity Contractor ("**ZPIC**") audits.

Judge Griswold acknowledged that, although there have been increased requests for hearings in each of these categories, the increase in appeals due to RAC and ZPIC post-payment audits is the most significant. RACs work to identify and correct Medicare improper payments through detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries and identification of underpayments to providers. ZPICs replaced the former Medicare Program Safeguard Contractors, and their primary task is to investigate instances of suspected fraud, waste, and abuse.

In Search of "Holistic" Solutions

Although OMHA is pursuing several programmatic initiatives to manage its caseload, Judge Griswold repeatedly referenced the need for a "holistic" solution across all levels of the Medicare appeals process in order to effectively address the backlog. Through the course of the Forum, OMHA personnel explained that the agency is working on a number of different solutions, both short- and long-term, that are intended to streamline

[1] U.S. Dep't of Health & Human Servs., Office of Medicare Hearings and Appeals, Memorandum to OMHA Medicare Appellants (Dec. 24, 2013), *available at* http://www.hhs.gov/omha/letter_to_medicare_appellants_from_the_calj.pdf. OMHA has published the slides shown at the Forum on its website, http://www.hhs.gov/omha/.

OMHA's caseload. However, the representatives acknowledged that no one approach is likely to provide an overall solution.

OMHA's proposed initiatives include:

- development of an adjudication manual so that all of OMHA's ALJs can follow uniform processes (OMHA hopes that this ultimately will foster greater consistency and predictability throughout the ALJ appeals process);

- consideration of statistical sampling methods, which only would be done with appellant consent, that could speed up the appeals process, particularly when an appellant has large numbers of claims that it is appealing;

- implementation of various alternative dispute resolution methods (OMHA is assessing its legal authority to engage in these alternative dispute options); and

- modernization of OMHA's IT infrastructure, including short-term solutions, such as the addition of a case tracker on the OMHA website so that appellants can view the status of their appeals online, and long-term solutions, such as the implementation of an electronic case adjudication and processing system to allow electronic filing and processing of appeals.

Reactions from Providers and Suppliers

Attendees at the Forum provided clear and repeated feedback regarding their impression of the "true problem"—namely, that until CMS resolves certain issues at the first two levels of the Medicare appeals process that are causing an inappropriately large number of denials at those levels, there is no chance of reducing OMHA's caseload. At the first level of the appeals process, known as "redetermination," a Medicare Administrative Contractor ("**MAC**") will review its own initial claims determination. At the second level of the appeals process, known as "reconsideration," a Qualified Independent Contractor ("**QIC**") will review the MAC's decision. In fiscal year 2012, MACs reviewed 2.9 million Medicare Part B claims determinations and upheld 1.4 million of these denials (Level I) and Part B QICs reviewed 628,000 MAC decisions and upheld 447,000 of these decisions (Level II).[2] Forum attendee commenters pointed out certain chronic issues, including large numbers of "technical" (versus "medical necessity") denials, and refusals by the MACs and QICs to reopen decisions when reconsideration may be appropriate. Although a few CMS staffers participated in the Forum, they were not aware of some of the issues and were unable to directly address these issues.

Additionally, many providers and suppliers that were represented at the Forum explained that the delays in appeals adjudication are threatening their continued

[2] Figures provided during OMHA Forum (Slide 90, titled "Medicare FFS Appeals Data Overview – FY 2012"), available at http://www.hhs.gov/omha/omha_medicare_appellant_forum_presentations.pdf. According to the slide, these figures include fully affirmed and partially reversed claims.

existence. This is a particularly significant concern for smaller providers and suppliers that are not able to survive financially while they wait for a hearing and then a decision. This problem is more acute for providers and suppliers that may be subject to recoupment of alleged overpayments while their appeals are pending. Attendees suggested several potential solutions to reduce the overall impact of the current backlog on providers and suppliers, including permitting "clinical inference" (i.e., a clinician's interpretation of a claim's appropriateness based on the medical record, considering the full scope of the Medicare beneficiary's circumstances) at all levels of the Medicare appeals process (currently, this is one of the significant distinctions at the ALJ level, as compared to the first two levels of the appeals process), and authorizing a stay on the automatic recoupment of overpayments given the protracted timeline of the ALJ process. Although Judge Griswold "made note" of these issues as various attendees raised them during the Q&A portions of the Forum, she reiterated that she and her colleagues at CMS and the Departmental Appeals Board are working together closely on a "holistic" solution to improve all levels of the Medicare administrative appeals process.

Key Takeaways and the New Reality of Level III Appeals

The consequence of OMHA's backlog is that providers and suppliers that file new Medicare appeals now should not expect those appeals to be heard by an ALJ until **August 2016, at the earliest**. This extended timeline can be financially devastating for many providers and suppliers that serve the Medicare population, particularly when recoupment of a disputed overpayment now occurs years in advance of the appellant's opportunity for an ALJ hearing.

A significant, but as yet unanswered, question is whether OMHA has the legal authority for deferring the assignment of timely filed ALJ appeals. According to Judge Griswold, OMHA has the legal authority to manage its workflow, even if doing so adds an extraordinary amount of time to the process. However, under both the Medicare statute and regulations, an ALJ is required to issue a decision within 90 days of the filing of a timely request for a hearing, unless that period is waived by the appellant, or the appellant elects to escalate the appeal to the Medicare Appeals Council, which is the next and last step in the CMS administrative appeals process. In reality, OMHA's deferred assignment policy extends the Level III appeals hearing timeline well beyond this 90-day period.

The other key question, made clear by numerous comments from Forum attendees, is whether CMS will react to the current problem and address the causes of the increase in OMHA's workload, in particular, the significant problems at the first two levels of the Medicare appeals process. These issues not only are, as commenters pointed out, the "true problem," but also are at least part of the cause that has led to the OMHA case backlog. Although OMHA representatives, including Judge Griswold, stated at several points during the Forum that OMHA "does not create policy" (except for policy to manage its case review and adjudication processes), CMS does have the necessary authority to change the appeals process at Levels I and II. In light of the many

comments regarding the problems at the first two levels of the appeals process, all eyes are on CMS. Might CMS host a similar forum to address the issues at the first two levels of the appeals process? Better yet, perhaps CMS will take the initiative to issue guidance that would revise and improve the appeals processes used by the MACs and QICs.

In her concluding remarks, Judge Griswold said that fixing the issues related to the Medicare appeals process will require collaboration among all stakeholders. To that end, OMHA will be publishing a notice in the *Federal Register* seeking recommendations. Timing for publication of this notice is unknown. However, providers and suppliers should track and consider this opportunity to provide OMHA and CMS with commentary "from the trenches."

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This Client Alert was authored by **Robert E. Wanerman, Amy F. Lerman,** *and* **Ali Lakhani***. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*

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