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Meeting the Challenge of Medicare Appeal Delays

By Following Certain Practices, a Provider or Supplier Can Facilitate the ALJ Adjudication Process

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Two years and counting…The Web site for the Office of Medicare Hearings and Appeals (OMHA) in the U.S. Department of Health and Human Services (HHS) recently announced: "Based on our current workload and volume of new requests, we anticipate that assignment of your request for hearing to an Administrative Law Judge may be delayed for up to **28 months**."[1] The lack of timely due process is increasingly a complaint being made about the appeals process for challenging Medicare claims denials. As the number of appeals continues to escalate and adjudicative resources remain constant, it is important to understand how a claims appeal can be expedited and moved more quickly to a favorable decision. Having previously served for six years as an Administrative Appellate Judge on the HHS Medicare Appeals Council,[2] I have been monitoring closely and with interest the issues associated with Medicare claims appeals.[3]

It is important to understand how this appeals process now finds itself in such dire straits. To do that one has only to review the history of the program. The big change came in 2000 when the appeals process for Medicare claims denials was changed dramatically by Congress. Five levels of review were established:

- redetermination by a Medicare administrative contractor (MAC);
- reconsideration by a qualified independent contractor (QIC);
- hearing before an administrative law judge (ALJ);
- review by the Medicare Appeals Council; and
- review by Federal District Court.

In an effort to further streamline the appeals process and make it responsive to the interests of

providers, suppliers, beneficiaries, and the Medicare Trust Funds, Congress subsequently transferred the responsibility for ALJ hearings from the Social Security Administration to HHS. And, in 2005, HHS established the OMHA, now comprised of approximately 60 ALJs, as well as support staff, to be responsible for handling all "Level 3" appeals of Medicare claims denials.

Burgeoning Caseload

It is important to understand the workload demands being placed on OMHA. In fiscal year (FY) 2013 (October 1, 2012 – September 30, 2013), it is estimated that approximately 329,000 requests for ALJ review involving almost 595,000 claims were received. During the same timeframe, the current 63 ALJs decided almost 103,000 appeals involving over 227,000 claims. These numbers need to be compared with cases received in the prior year to see how dramatically the appeal numbers have increased. In FY 2012, 130,000 requests for ALJ review were received encompassing over 312,000 claims. Thus, there was over a 150 percent increase in the number of requests for ALJ review while the number of ALJs did not increase.

The Senate Appropriations Committee recently recommended increasing OMHA's funding in FY 2014, recognizing "the growing backlog of cases at OMHA and the high rate of claims overturned by th[at] Office." In light of the current Congressional gridlock, however, it is doubtful that OMHA will receive this increased funding.

Facilitating Better and More Timely ALJ Decisions

Based on experience, I believe that there are reasonable strategies that a provider or supplier can use to facilitate a more timely and favorably decision. They include:

- **Introducing Evidence at the QIC Level of Review:** One critical consideration is the need for a provider or supplier to introduce all relevant and material evidence at the QIC level of review. Both the law and regulations provide that, "absent good cause, failure to submit all evidence prior to the issuance of the [QIC's] reconsideration precludes subsequent consideration of that evidence."[4] Increasingly, ALJs are denying the late submission of additional evidence because "good cause" is not established. Thus, cases are being decided by ALJs without all the appropriate documentation being considered.
- **Submitting a Prehearing Memorandum:** Another technique for assuring that timely and favorable consideration is given to an appeal of a Medicare claims denial is the submission of a concise "ALJ Appeal Memorandum" or "Prehearing Brief" to the ALJ prior to the scheduled hearing. Such a document should include:
  (1) Proposed Findings of Fact;
  (2) Conclusions of Law;
  (3) Summary of Supporting Evidence; and
  (4) Explanation as to why the law and evidence support a favorable decision.

  A prehearing submission to an ALJ should identify the relevant and supporting provisions of law, regulations, national coverage determinations (NCDs), local coverage determinations (LCDs), and Medicare Manual provisions. In addition, it should reference the specific exhibits and documents that support Medicare coverage and payment of the claims at issue. Often, an ALJ will request such a prehearing submission to obtain a "roadmap" for reaching a decision. In many cases, ALJs are incorporating proposed findings of fact and conclusions of law into favorable decisions.
- **Focusing on Key Issues**: Finally, a strategy is needed to ensure that all legal

authority and evidence are presented to the ALJ on the key issues to be decided. These issues are:

(1) Is there a Medicare benefit category covering the claimed items or services? For example, Medicare Part B covers "medical and other health services,"[5] and these services are defined at 42 USC 1395x(s). An appellant must establish that the claimed items or services are encompassed by a Medicare benefit category.

(2) Is there a statutory preclusion of coverage of the claimed items or services? For example, under 42 USC 1395y(a)(1)(18), if a beneficiary is receiving skilled nursing facility (SNF) services that are covered under Medicare Part A, no items or services may be simultaneously covered and paid for under Medicare Part B. An appellant must establish that the claimed items or services are not statutorily excluded from coverage.

(3) Is there evidentiary support that the claimed items and services were "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," as required by 42 USC 1395y (a)(1)(A). If there is an applicable NCD, the ALJ is required to apply its specifications to the items or services at issue in deciding whether they were "reasonable and necessary."[6] An appellant must establish that there is documentation and related evidence/testimony to support a finding that the claimed items or services were "reasonable and necessary" for the beneficiary.

Conclusion

There is obviously no established formula for securing a timely and favorable decision from an ALJ reviewing the denial of Medicare coverage and payment of claims. The overwhelming number of appeals being filed and pending at OMHA inevitably will result in delays. Realistically, the current cadre of ALJs can only handle a finite number of hearings and still issue fair, comprehensive, well-reasoned decisions. By following certain practices, however, a provider or supplier can facilitate the ALJ adjudication process.

It needs to be recognized that each case presents different statutory and evidentiary issues. Therefore, to the extent that an appellant can provide guidance and assistance to an ALJ in identifying the key legal authority and evidence in a case, that will help in securing a timely and favorable decision. *See* also www.compliance.com/compliance-challenge-appealing-medicare-claim-denials.

Endnotes:

1. www.hhs.gov/omha/for_appeals_submitted_after_july_15,_2013_.html.
2. www.compliance.com/our-team/tom-herrmann.
3. *See* www.compliance.com/the-medicare-appeals-process-is-it-working-in-2013.
4. 42 CFR 405.966.
5. 42 USC 1395k (a) (2) (B).
6. 42 CFR 405.1060(b).

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