

If you have questions or would like additional information on the material covered in this Alert, please contact one of the authors:

Scot T. Hasselman

Partner, Washington, D.C.
+1 202 414 9268
shasselman@reedsmith.com

Rahul Narula

Associate, Washington, D.C.
+1 202 414 9270
rnarula@reedsmith.com

...or the Reed Smith lawyer with whom you regularly work.

CMS Still Finding Its Way Through Significant Medicare Appeals Backlog – Proposes New Rule in an Effort to Catch Up

In the proposed rule, CMS focuses on taking administrative actions to alleviate the backlog, including introducing the concept of precedential decisions, delegating certain administrative law judge tasks to “attorney adjudicators” and clarifying certain evidentiary requirements within the administrative appeal process.

The Centers for Medicare & Medicaid Services (CMS) recently issued a proposed rule¹ to address the significant backlog resulting from “an unprecedented and sustained increase” in its Medicare appeals. According to CMS, the Office of Medicare Hearings and Appeals (OMHA) had more than 750,000 pending appeals as of April 30, 2016, while it has only an adjudication capacity of 77,000 appeals per year.² Given the current backlog, the statutory 90-day limit³ for a decision at the Administrative Law Judge (ALJ) level (the third level of the administrative appeal process) is routinely ignored by OMHA – the current average wait time is more than five times this congressionally mandated time limit.

CMS has previously identified four primary drivers for the growth in Medicare appeals – (1) an increase in the number of beneficiaries; (2) updates and changes to Medicare and Medicaid coverage and payment rules; (3) growth in appeals from State Medicaid Agencies; and (4) national implementation of the Medicare Recovery Audit Contractor Program.⁴ Under current resources (and without any additional appeals), CMS projects it would take 11 years for OMHA and six years for the Medicare Appeals Council (MAC) (the fourth and highest level of the administrative appeal process before federal district court) to process their respective backlogs.⁵

Highlights of the Proposed Rule The proposed rule comes on the heels of criticism from various branches of the federal government regarding the delay

in processing Medicare appeals, including a recent Government Accountability Office Report⁶ identifying opportunities to improve the appeals process; the D.C. Circuit Court of Appeals' recent reversal and remand in *American Hospital Association v. Burwell*⁷; a Senate Finance Committee hearing in April 2015 titled "Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare"⁸; and OMHA's own "Medicare Appellant Forum"⁹ in 2014.

In the proposed rule, CMS specifies a three-prong approach to addressing the current backlog – (1) requesting new resources to increase adjudication capacity; (2) taking administrative actions to reduce pending appeals and implement new strategies to alleviate current backlog; and (3) proposing legislative reforms that provide additional funding and new authorities to address the volume of appeals. The proposed rule focuses on the second prong, with the major highlights of the proposed rule as follows:

- **MAC Precedential Decisions** The proposed rule designates the Departmental Appeals Board chair to select MAC decisions in "which a significant legal or factual issue was fully developed on the record and thoroughly analyzed" as precedential and binding on CMS and its contractors in making initial determinations, redeterminations, and reconsiderations in an effort to provide more consistency in appeals decisions.¹⁰ To potentially minimize the number of appeals filed, CMS would provide a public listing (including being posted on the CMS website) of such final precedential decisions in order for appellants to evaluate whether to move forward with the appeals process.¹¹

In the proposed rule, CMS explains that if a MAC decision is designated as precedential and interprets a CMS manual instruction, that interpretation would be binding on pending and future appeals and initial determinations to which that manual instruction applies.¹² Presumably, Medicare contractors will be trained with interpreting and processing appeals submitted for their review that relates to an issue that has a binding precedential decision. In order to maintain final authority, CMS would be free to follow its normal internal process to revise a manual instruction at issue, and such new instruction would apply to initial determinations superseding the precedential decision designated by the MAC.

- **Attorney Adjudicators** The proposed rule includes a provision to expand OMHA's adjudicator pool by allowing OMHA to reassign a portion of its workload to non-Administrative Law Judge adjudicators, to be known as "attorney adjudicators." Specifically, the proposed rule would allow such attorney adjudicators to issue decisions when an appellant decides it does not want a hearing, or withdraws his or her request for an ALJ hearing.¹³

Attorney adjudicators would also address whether a Qualified Independent Contractor (QIC) dismissal was in error – an occurrence CMS identifies as

having happened more than 350 times last year.¹⁴ Decisions by attorney adjudicators can be reopened or appealed the same as if the ALJ made the decision. Under the proposed rule, the term “attorney adjudicator” would be defined as a “licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance.”¹⁵

- **Admission of New Evidence at ALJ Level** The proposed rule more clearly explains the criteria for which “new evidence” may be submitted at the ALJ level of appeal. Currently, any evidence that was not submitted during the first two levels of appeal will not be admitted at the ALJ level unless a party can demonstrate “good cause” for its admission.¹⁶ The current regulations provide limited context regarding what is considered “good cause,” leaving a fair amount of discretion to the ALJ for such a determination. The proposed rule provides more clarity and consistency to appellants as to when new evidence may be admitted.

Under the proposed rule, new evidence may be admitted where (1) the ALJ or attorney adjudicator finds that the new evidence is material to an issue addressed in the qualified QIC’s reconsideration decision, and the issue was not identified as a material issue prior to the QIC’s decision; (2) the new evidence is material to a new issue identified in the QIC’s decision; (3) the party was unable to obtain the evidence before the QIC issued its reconsideration decision, and the party submits evidence that establishes the party’s reasonable attempts to obtain the evidence before the decision was made; (4) the evidence was submitted by the party to the QIC but it was not included in the administrative record; and (5) the ALJ or attorney adjudicator determines the party has demonstrated that it could not have obtained the evidence before the QIC issued its reconsideration.¹⁷

Analysis for Medicare Providers CMS has struggled in adopting measures to curtail the Medicare appeals backlog, as previous measures to reduce the backlog included reliance on technological advancements in case filing and processing, which has not been sufficient.¹⁸ The most significant modification to the appeals process under the proposed rule is the adoption of precedential decisions. The concept of precedential decisions is not new – in fact, the Office of Inspector General (OIG) recommended CMS implement precedential decisions back in 1999 after reviewing the Medicare Appeals Process and determining inconsistencies across ALJs and contractor decisions.¹⁹ At that time, CMS determined it was not “feasible or appropriate” to confer precedential authority on MAC decisions, citing its inability to participate as a party in ALJ hearings (the regulations now permit such authority), and the Social Security Administration’s transfer of responsibility for adjudicating Medicare appeals to CMS under the Medicare Prescription Drug, Improvement and Modernization Act of 2003.²⁰

Although the adoption of precedential decisions should help restrain inconsistent ALJ decisions, providers should monitor how CMS plans to instruct and educate

its Medicare contractors in properly implementing such precedential decisions at lower levels of appeal – with various Medicare contractors and QICs, the prospect for inaccurate interpretation and implementation of such decisions remain. In circumstances in which a precedential decision would apply to a factual question, CMS explains that the “decision would be binding where the relevant facts are the same and evidence is presented that the underlying factual circumstances have not changed” since the MAC issued the precedential decision.²¹ For providers concerned with Medicare claims relating to medical necessity, CMS recognizes that “many claim appeals turn on evidence of a beneficiary’s condition or care at the time discrete items or services are furnished,” and therefore the proposed rule on precedential decisions “is unlikely to apply to findings of fact in these appeals.”²²

The establishment of precedential decisions does not remove a party’s right to challenge such decisions by seeking judicial review in federal court for an unfavorable MAC decision.²³ It remains unclear whether CMS will allow a party to seek judicial review immediately following a determination that its appeal is denied based on precedential authority, or whether said party would need to continue moving through the appeals process for a final MAC decision.

Although the proposed rule specifies that attorney adjudicators would receive the same training as OMHA ALJs – it remains to be seen whether the establishment of “attorney adjudicators” will compromise the quality and thoroughness of review. Finally, the proposed rule is silent on modifications CMS previously has suggested to mitigate the backlog, such as implementing an alternative dispute model, as well as including OMHA facilitated mediation of claims.

Conclusion Provider frustration with the Medicare appeal process is warranted. With the increase in audit reviews, particularly of the pre-payment variety, the current Medicare appeals backlog creates a real disadvantage for providers whose cash flow is interrupted – delays in contesting such reviews halts critical cash-flow. When providers can get a timely ALJ hearing, the process has shown to offer success to providers – in 2010, more than 56 percent of ALJ decisions were fully favorable to providers.²⁴

In a blog post announcing the release of the proposed rule, Chief Administrative Law Judge Nancy Griswold and Departmental Appeals Board Chair Constance B. Tobias noted that the president’s 2017 proposed budget requests additional funding and legislative reforms to facilitate appeals processing and encourage resolution of appeals earlier in the process. Even if Congress grants the administration’s requests, however, Griswold and Tobias acknowledged that the backlog of appeals still would not be eliminated before 2021. Consequently, providers should continue to monitor the proposed rule and the modifications contemplated by CMS, and insist for additional measures to relieve the significant backlog.²⁵

- ¹ 81 Fed. Reg. 43790 (July 5, 2016).
- ² *Id.* at 43792.
- ³ Section 1869(d)(1)(A) of the Act; 42 C.F.R. § 405.1046.
- ⁴ See HHS Primer – Medicare Appeals Process *available at*: <http://www.hhs.gov/dab/medicare-appeals-backlog.pdf>
- ⁵ *Id.*
- ⁶ See Opportunities Remain to Improve Appeals Process, GAO-16-366 (May 10, 2016)
- ⁷ 812 F.3d 183, 185 (D.C. Cir. 2016).
- ⁸ See Full Committee Hearing Transcript, *available at*: <http://www.finance.senate.gov/hearings/creating-a-more-efficient-and-level-playing-field-audit-and-appeals-issues-in-medicare>
- ⁹ See Medicare Appellant Forum, *available at*: http://www.hhs.gov/omha/files/appellant_forum_presentations.pdf
- ¹⁰ 81 Fed. Reg. at 43793-43794.
- ¹¹ *Id.*
- ¹² *Id.*
- ¹³ *Id.* at 43794-43795.
- ¹⁴ *Id.*
- ¹⁵ *Id.*
- ¹⁶ 42 C.F.R. § 405.1028.
- ¹⁷ *Id.* at 43829.
- ¹⁸ In 2014, OMHA held a “Medicare Appellant Forum” to provide some insight of the future of the appeals process. At the forum, OMHA announced various short-term and long-term initiatives to curtail the appeals backlog, including programmatic changes as well as technological advancements. See Medicare Appellant Forum, *available at*: http://www.hhs.gov/omha/files/appellant_forum_presentations.pdf
- ¹⁹ See Office of Inspector General Report, Medicare Administrative Appeals (September 1999) *available at*: <https://oig.hhs.gov/oei/reports/oei-04-97-00160.pdf>. CMS would not be the only agency to rely on precedential decisions, as other federal governmental administrative forums utilize precedential decisions, including the National Labor Relations Board (NLRB) and United States Citizenship and Immigration Services (“USCIS”) to expedite their administrative process.
- ²⁰ See Report to Congress: Plan for the Transfer of Responsibility for Medicare Appeals (Mar. 2004) *available at*: https://www.ssa.gov/legislation/medicare/medicare_appeal_transfer.pdf.
- ²¹ See 81 Fed. Reg. at 43793-43794.
- ²² *Id.*
- ²³ See 42 C.F.R. § 405.1136.
- ²⁴ See OIG Report, Improvements are needed at the Administrative Law Judge Level of Medicare Appeals, (November 2012) *available at*: <https://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>
- ²⁵ The proposed rule is open for comments through 5 p.m. EDT August 29, 2016.

This *Alert* is presented for informational purposes only and is not intended to constitute legal advice.

© Reed Smith LLP 2016.
All rights reserved. For additional information, visit <http://www.reedsmith.com/legal/>