Part B Insider (Multispecialty) Coding Alert

Appeals: Medicare Appeals Could Change Dramatically

Early stage appeals need to be more accurate.

Nearly everyone agrees that Medicare's appeal system has essentially stopped functioning, but will a fix create an even bigger burden for you? Recent congressional action on the matter is shedding light on the issue.

Last month, the U.S. Senate Finance Committee convened a hearing to discuss the Medicare claims appeals backlog. The Committee heard from the HHS Office of Medicare Hearings and Appeals' (OMHA) Chief Administrative Law Judge **Nancy Griswold,** as well as other industry stakeholders. Committee Chair Sen. **Orrin Hatch** (R-Utah) and Ranking Member Sen. **Ron Wyden** (D-Ore.) led the hearing. On June 3, the Committee approved the proposal, allowing it to move forward through the Congressional system.

Background: When the Department of Health and Human Services created OMHA in 2005, the Office was initially able to meet the regulatory-mandated 90-day timeframe for most appeals, Griswold testified. But beginning in 2010 — partially due to appeals from the nationwide expansion of the Recovery Audit Contractor (RAC) program — OMHA's workload began to increase rapidly.

ALJ team productivity has more than doubled in the past five years, but still "the magnitude of the increase in workload has exceeded OMHA's ability to adjudicate incoming appeals within the 90-day timeframe that Congress contemplated for most appeals," Griswold noted. Adjudication timeframes are now 572 days "and will continue to increase until receipt levels and adjudication capacity are brought into balance."

Funding increases in fiscal year 2014 and FY 2015 have allowed OMHA to hire 12 additional ALJ teams, bringing its adjudication capacity to 77,000 appeals, Griswold said. Unfortunately, this still doesn't even come close to meeting the demand — OMHA received more than 384,000 appeals in FY 2013 and 474,000 appeals in FY 2014 alone.

Currently, there are more than 500,000 appeals pending review and 870,000 pending appeals at the ALJ level, with only 60 officers assigned to handle cases, according to a recent analysis by law firm Wachler & Associates. Griswold urged the Committee to support **President Obama's** proposed FY 2016 budget, which would boost OMHA's budget by about $300 million.

This funding increase would allow OMHA to hire additional ALJs and perhaps magistrates, which OMHA estimates would increase the number of appeals adjudicated per year from 77,000 to 278,000. But the number of appeals in FY 2013 and FY 2014 exceeded this figure, so clearly a budget increase alone won't solve OMHA's problems.

MAC Reviewers Deny 98% of Appeals

Sympathetic ear: Sen. Hatch blamed the backlog on the "insurmountable increase in appeals," although he did acknowledge the contributing factor of preventing improper Medicare payments — 60 percent of the appeals are found in favor of the defendants. Sen. Hatch expressed concern for providers that are potentially facing undue burdens and questioned whether Medicare contractors were making improper payment decisions. Stakeholders also point to inefficiencies in the lowest review levels as contributing to the enormous backlog of appeals.

More problems: The first-level reviews deny coverage 98 percent of the time, a rate "so ludicrously low as to be no review at all," according to a recent statement by the Center for Medicare Advocacy. "The irony is that the review process changes made in the last decade were supposed to make the lowest levels of review a more efficient and effective part of the process, so that beneficiaries would not be forced to go to the ALJ level."

But with success virtually impossible at the lowest review level, beneficiaries must continue their appeals to the ALJ level for any chance of success, the CMA lamented. And unfortunately, the Committee hearing "did not consider these 'rubber stamp' denials at the lower levels of review, which contractors are paid hefty sums to administer."

Earlier this month, Senate Finance passed legislation to counteract some of the problems outlined in the hearing. The Committee passed a bill that would require CMS to establish incentives for auditors to ensure accuracy and allow multiple pending appeals with similar issues to be settled as a unit, notes law firm Hall Render in analysis. The legislation would also require CMS to provide $127 million to OMHA and the Departmental Appeals Board. And the bill incorporates an amendment to have HHS develop a process for auditors to notify providers of pending audits and requests for medical documentation, Hall Render notes.

Should You Settle?
Don't let the backlogs discourage you from fighting for the reimbursement you deserve. "Despite the appeal backlog and processing time, Medicare providers and suppliers must continue to appeal Medicare contractors' overpayment determinations and preserve their appeal rights," Wachler & Associates urged.

Last year, in response to the increasing backlog, CMS offered hospitals an "administrative agreement mechanism" in which you could agree to dismiss the appeal and in return CMS would agree to a partial repayment of the claims in question, according to attorney **Knicole C. Emanuel** with Gordon & Rees in Raleigh, N.C. "Specifically, the hospital will be reimbursed for 68 percent of the disputed claims."

But this mechanism pertains only to hospitals, and CMS will offer this partial payment only if no other appeals are pending which leaves out providers with multiple appeals, Emanuel says. "As in, you must dismiss all lawsuits in order to receive the partial payout."

"Personally, I call this a raw deal," Emanuel laments. One reason she cites is that the RAC's determinations are not always right, so "why take 68 percent when you are owed 100 percent?"