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New resolution opportunities in the Medicare appeals process

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Congress designed Medicare's administrative appeals process as an expedited resolution process for denied Medicare reimbursement claims. In fact, the Social Security Act prescribes specific timeframes within which Medicare appeals must be decided at each level of the administrative appeals process.[1] At the third level of the appeals process, which involves a hearing before an Administrative Law Judge (ALJ), Medicare appeals must be heard and decided within 90 days of a receipt of a request for hearing. According to statistics released by the Office of Medicare Hearings and Appeals (OMHA), the division of the U.S. Department of Health and Human Services (HHS) that administers ALJ hearings, beginning in 2008, OMHA began to receive more ALJ appeals than it could process, creating a backlog in the appeals process. In 2009, OMHA's average appeal processing time was 94.9 days, largely complying with federal mandate. That figure has steadily risen each consecutive year, and in 2017, OMHA's average appeal processing time exceeded 1,057 days.[2]

The excessive adjudication delay has taken a significant financial toll on the Medicare provider and supplier community. The American Hospital Association (AHA) estimated that the value of Recovery Audit Contractor (RAC) appealed claims exceeded $1.8 billion. This figure does not include the value of non-RAC appealed claims, which are also caught in the appeals backlog.[3]

Medicare providers and suppliers have called upon HHS, Congress, and the Courts to fashion remedies to the backlogged appeals process. The Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM) (S.2368) was introduced in the Senate and placed on the Senate legislative calendar on December 8, 2015. AFIRM proposed several reforms to the Medicare audit process, and although Congress has taken no action on AFIRM in well over two years, HHS has implemented on its own accord various reforms to the Medicare appeals process that are discussed in greater detail below. Judicial relief has been similarly slow. In 2014 the AHA and other healthcare providers filed suit in federal court against HHS, seeking a court order that HHS clear the backlog and comply with the 90-day statutory timeframe for ALJ hearings. The case is currently pending on remand before the United States District Court for the District of Columbia to evaluate HHS's claim that it is legally impossible to comply with a four-year resolution timetable as proposed by the AHA to reduce the backlog. According to this timetable, HHS would be required to reduce the backlog by 30% by 2018, 60% by 2019, 90% by 2020, and 100% by 2021.[4]

Congressional and judicial relief has been slow, but over the past years, HHS has released various initiatives to both reduce the backlog of pending appeals and curtail the filing of new appeals in the Medicare appeals process. These initiatives are welcome opportunities for Medicare providers and suppliers to achieve expedited resolution to pending appeals.

Low Volume Appeals settlement

On November 3, 2017, CMS announced a settlement opportunity for Medicare Part A and Part B providers and

suppliers (appellants) with eligible fee-for-service appeals pending in the administrative appeals process. CMS titled this opportunity the Low Volume Appeals (LVA) settlement, because it allows appellants with less than 500 appeals pending before the ALJ or Medicare Appeals Council (the Council) levels of review, combined, to withdraw pending, eligible appeals from the backlogged Medicare appeals process in exchange for a non-negotiable settlement sum as final resolution of the disputed appeals. Through the LVA settlement, appellants will receive 62% of the net Medicare approved amount of their eligible claims.

The LVA settlement is not the first settlement opportunity offered by CMS. In October of 2014 and November of 2016, CMS offered to pay eligible hospitals 68% and 66% of the net payable amount of their patient status claim denials in exchange for the hospital's acceptance of an administrative agreement as the full and final administrative and legal resolution of their claims. CMS defined patient status claims as claims denied on grounds that inpatient reimbursement for hospital services was not medically reasonable and necessary, but outpatient reimbursement would be appropriate. This settlement opportunity resolved approximately 346,000 claims from the backlogged Medicare appeals process. By August of 2016, CMS had executed settlements with 2,022 hospitals, amounting to nearly $1.47 billion dollars paid to participating hospitals.[5] Although these settlements were attractive opportunities for eligible hospitals, large volumes of claims remained backlogged in the appeals process.

The LVA settlement has broader appellant eligibility criteria than the prior settlements. All Medicare Part A and Part B providers and suppliers are eligible, as long as they have less than 500 eligible appeals pending at the ALJ and Council levels of appeal, combined. Also, unlike the prior settlements, the LVA settlement contains no date of service restriction on eligible claims.

CMS provided the following appeal eligibility criteria for the LVA settlement:

- The appeal was pending before the OMHA and/or Council level of appeal as of November 3, 2017;
- The appeal has a total billed amount of $9,000 or less;
- The appeal was properly and timely filed at the OMHA or Council level as of November 3, 2017;
- The claims included in the appeal were denied by a Medicare contractor and remain in a fully denied status in the Medicare system;
- The claims included in the appeal were submitted for payment under Medicare Part A or Part B;
- The claims included in the appeal were not part of an extrapolation; and,
- As of the date the LVA settlement agreement is fully executed, the appeal was still pending at the OMHA or Council level of review.[6]

Appellants may be excluded from LVA settlement based on False Claims Act (FCA) litigation or investigation or other program integrity concerns, including pending civil, criminal, or administrative investigations. As with the other settlement opportunities, a participating appellant cannot choose to settle some eligible claims and not others. CMS has clarified that eligibility criteria are at the "appeal" rather than the "claim" level. This distinction is relevant, because the federal regulations permit appellants to batch or consolidate claims with similar issues of law and fact into one appeal for adjudication. Therefore, if the total billed value of the consolidated appeal exceeds the $9,000 cap, CMS would consider the appeal ineligible for LVA settlement, regardless of whether the individual claims have billed values well below the $9,000 cap. CMS has also suggested that if multiple claims were consolidated into one appeal and assigned one appeal number, those claims will be considered one appeal for purposes of the LVA settlement. For example, if a provider has consolidated for ALJ appeal 10 claims, each

with a billed value of $1,000, and one ALJ appeal number has been issued regarding all 10 claims, OMHA would consider this as one appeal for purposes of LVA settlement. The billed value of the consolidated appeal would be $10,000, and these claims would be ineligible for the LVA settlement.

CMS created two separate participation periods for the LVA settlement to manage the volume of participants in the process and ensure timely processing of all requests. An appellant's National Provider Identifier (NPI) number will determine when it may request participation. To participate in the LVA settlement, an appellant should submit an Expression of Interest (EOI) form to CMS. For appellants with NPIs ending in an even number, EOIs will be accepted beginning on February 5, 2018 through March 9, 2018. If an NPI ends in an odd number, EOIs will be accepted beginning on March 12, 2018 through April 11, 2018. If an appellant has both an odd NPI and even NPI, it should submit an EOI for each NPI according to the timeframes above.

The LVA settlement is a fully voluntary process that allows an appellant to retain full appeal rights until it signs the settlement agreement and submits it to CMS. However, once the settlement agreement is signed by the appellant and CMS, all claims identified as eligible on the final spreadsheet will be placed in a "pended" status with CMS and OMHA, and any proceedings on these claims will be stayed. If an appellant wishes to abandon the LVA process prior to execution of the settlement agreement, the appeals will remain in the normal appeals process and retain their place in queue for administrative resolution. Any specific appeals determined to be ineligible for settlement will return to their position in the appeals process.

Interested appellants should note that as of the date an appellant signs the settlement agreement, it will not know the exact net settlement value of the eligible appeals. Therefore, prior to signing the settlement agreement, appellants should prepare an educated estimate of their anticipated settlement payout under the LVA process.