BURR ARTICLE

End in Sight for Medicare ALJ Backlog?

By Kelli Fleming January 17, 2017

Reprinted with Permission from the *Birmingham Medical News*

As providers who are currently undergoing a Medicare claims appeal know, there is a lengthy delay to having an appeal actually heard by an Administrative Law Judge ("ALJ"). Some estimates indicate that it will currently take over ten (10) years to have an appeal heard. Due to a recent Court Order, that delay may be shortening over the years to come, which brings much needed relief to providers awaiting an ALJ hearing.

Before discussing the recent Court Order, a brief review of the Medicare claims appeal process is in order. When a provider receives notice that a Medicare claim has been improperly paid and that an overpayment exists, the provider has the right to appeal that decision. The first level of appeal is called a Redetermination. Under the Redetermination phase, the appeal is heard by the provider's Medicare Administrative Contractor ("MAC") based on written submission. While the provider has 120 days to file a Request for Redetermination review, if the request is filed within thirty (30) days, the filing stays the recoupment of funds. In other words, the appeal filing prevents the MAC from offsetting the alleged overpayment with current or future amounts owed to the provider. This stay is a huge benefit for providers who disagree with the overpayment finding and are pursuing an appeal.

Following the Redetermination review, if the decision remains unfavorable to the provider, the provider may file a second level of appeal called a Reconsideration. Under the Reconsideration phase, the appeal is heard by a Qualified Independent Contractor based on written submission. While the provider has 180 days to file a Request for Reconsideration review, if the request is filed within sixty (60) days, the filing once again stays the recoupment of funds by the MAC.

Following the Reconsideration review, if the decision remains unfavorable to the provider, the provider may file a third level of appeal with the Office of Medicare Hearings and Appeals ("OMHA"). This appeal is heard by an ALJ and is the first opportunity the provider has to a live hearing—as opposed to review based solely on written submission. While the provider has sixty (60) days to file the request for an ALJ hearing, there is no opportunity at this level to delay recoupment. In other words, despite the fact that an appeal has been filed, the MAC may offset Medicare funds. Arguably to counter-balance this downside to the provider, the OMHA is legally required to grant the provider a hearing and a decision within ninety (90) days of the appeal request.

However, in recent years, due to the large number of appeals being filed, the OMHA has not been able to meet its 90-day deadline. In fact, the delay to obtain an ALJ hearing has grown exponentially and the latest report from the OMHA indicates that it will take approximately ten (10) years for the OMHA to process its backlog of appeals. All the while, Medicare may offset Medicare funds to recoup the disputed overpayment. As you can imagine, depending on the size of the alleged overpayment, this delay

combined with the offset of Medicare funds can be devastating for a provider, and, in some instances, drive a provider out of business.

In response to this delay and the detrimental impact on providers, the American Hospital Association filed suit against The Department of Health and Human Services ("HHS") for its failure to meet the legally required deadline and in attempts to push for a resolution of the backlog. After a lengthy court proceeding, the details of which are beyond the scope of this article, the United States District Court for the District of Columbia recently issued its Order in favor of the American Hospital Association. The Court ordered HHS to resolve the current backlog of ALJ appeals by meeting the following reductions in current case volume:

- **30% reduction by December 31, 2017;**
- **60% reduction by December 31, 2018;**
- **90% reduction by December 31, 2019; and**
- **100% reduction by December 31, 2020**.

In addition, HHS must file status reports with the Court every ninety (90) days.

What remains to be seen is how HHS will achieve this reduction with its current budget restraints. While several proposals were discussed among the parties in the course of the legal proceeding, the Court refused to place specific procedural limitations on the federal agency, leaving HHS with discretion in how best to achieve the Order's targets.

If the decision stands (at the time of writing this article, an appeal had not yet been filed by HHS), it will provide some much needed relief to providers currently awaiting an ALJ hearing. While providers will still not receive a hearing within the ninety (90) day period, instead of having to wait the perceived ten (10) years for an ALJ hearing, as predicted, current appeals will be heard sometime within the next four (4) years. Stay tuned to see if an appeal is filed by HHS or how HHS will meet the Court-ordered reduction in case volume.

For more information, please contact:

Kelli Carpenter Fleming

Birmingham, AL
Phone (205) 458-5429
E-Mail kfleming@burr.com

Kelli Fleming is a Partner with Burr & Forman LLP practicing within the firm's Birmingham office. Kelli practices exclusively within the firm's Health Care Industry Practice Group.