

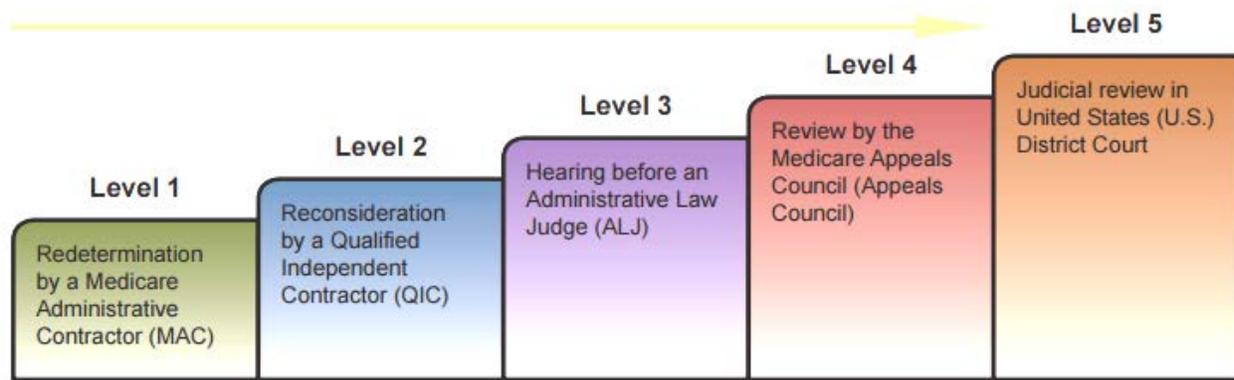
HHS Primer: The Medicare Appeals Process

Introduction

Every year, Medicare Administrative Contractors (MACs) process an estimated 1.2 billion fee-for-service claims on behalf of the Centers for Medicare & Medicaid Services (CMS) for more than 33.9 million Medicare beneficiaries who receive health care benefits through the Original Medicare program. Accurate and efficient payment and processing of claims for the services these beneficiaries receive is important to ensuring the integrity of the Medicare program. When Medicare beneficiaries or providers disagree with a coverage or payment decision made by Medicare, a Medicare health plan, or a Medicare Prescription Drug Plan, they have the right to appeal.

The U.S. Department of Health and Human Services (HHS) continues to strengthen Medicare program integrity to combat all improper payments, including fraud, waste, and abuse, and to protect the rights of Medicare beneficiaries and stakeholders through the Medicare appeals process.

The Social Security Act (the Act) establishes five levels to the Medicare appeals process: redetermination, reconsideration, Administrative Law Judge hearing, Medicare Appeals Council review, and judicial review in U.S. District Court.



First Level of Appeal: Redetermination

At the first level of the appeal process, the MAC processes the redetermination. Appellants have 120 days from the date they receive the initial claim denial to file a request for redetermination. The Act does not require a minimum amount-in-controversy. The Act contemplates that the MAC is to complete a redetermination within 60 days after the MAC receives the request for redetermination.

Second Level of Appeal: Reconsideration

A Qualified Independent Contractor (QIC) processes reconsiderations. Parties dissatisfied with the outcome of a MAC redetermination have 180 days from the date they receive the redetermination decision to file a request for reconsideration. The QIC reconsideration process may include an independent review of medical necessity issues by a panel of physicians or other appropriate health care

professionals. A minimum amount-in-controversy is not required. The Act and implementing regulations contemplate that a QIC will complete the reconsideration and send a decision to the parties within 60 days after the date a request for reconsideration is timely filed with the appropriate QIC. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of his or her rights and the procedures to escalate the case to an Administrative Law Judge (ALJ).

Third Level of Appeal: Hearing before an Administrative Law Judge (ALJ)

If a party is dissatisfied with a QIC reconsideration, the party has 60 days from the date of receipt of the QIC reconsideration to file a request for a hearing before an ALJ at the Office of Medicare Hearings and Appeals (OMHA), which is independent from CMS. This provides parties a fair and impartial forum to address disagreements with CMS Medicare coverage and payment determinations. A minimum amount-in-controversy is required for a hearing (the amount is adjusted annually based on a formula prescribed by statute; and for 2016, the minimum amount-in-controversy for a claim appealed to OMHA is \$150). Section 1869(d)(1)(A) of the Act contemplates that an ALJ conduct a hearing and render a decision within 90 days beginning on the date the request for hearing is filed. If the ALJ does not render a decision within the timeframe contemplated by the Act, the party that requested the hearing may request a review by the Medicare Appeals Council at the HHS Departmental Appeals Board (DAB). Due to an overwhelming number of hearing requests over the past several years, OMHA has not been able to meet the 90-day time-frame for adjudication in some cases, resulting in a backlog of appeals at OMHA.

Fourth Level of Appeal: Medicare Appeals Council Review

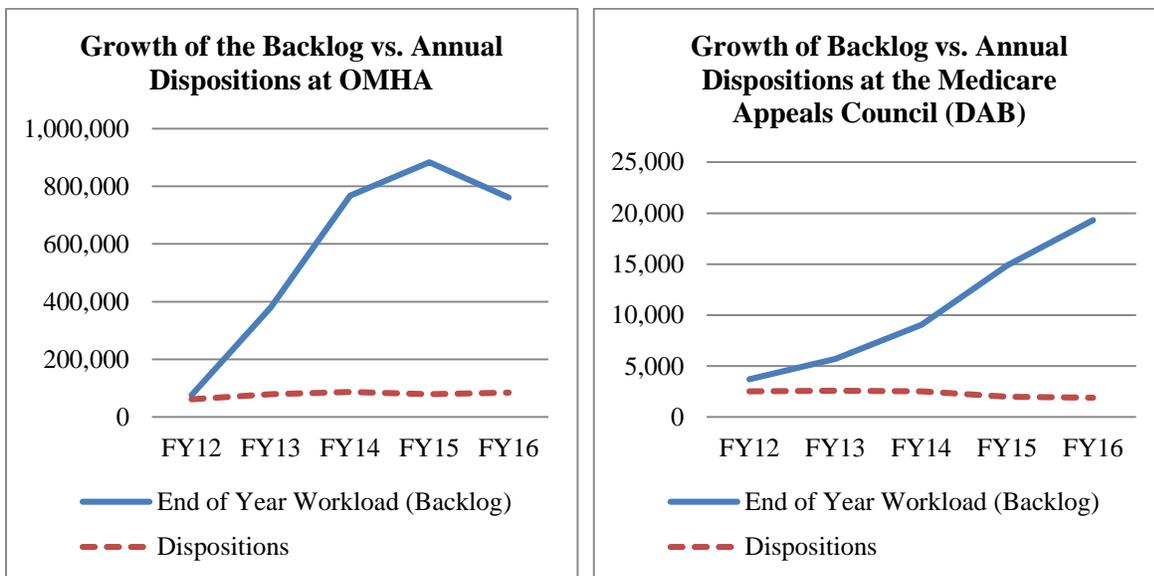
The Medicare Appeals Council (Council) reviews appeals of ALJ decisions. The Council's Administrative Appeals Judges are located within the HHS Departmental Appeals Board (DAB), and the Council is independent of both CMS and OMHA. The Council provides the final administrative review for Medicare claim appeals. Parties dissatisfied with the outcome of an ALJ decision have 60 days from the date of receipt of the ALJ's decision to file a request for Council review. Appellants may also file a request with the Council to escalate an appeal from the ALJ level if the ALJ has not completed his or her action on the request for hearing within the adjudication deadline. Section 1869(d)(2)(A) of the Act contemplates that the Council render a decision or remand the case to the ALJ within 90 days from the date the request for review is timely filed. If the Council does not render a decision within 90 days, the appellant may request that the appeal be escalated to Federal district court. Due to an overwhelming number of Council review requests over the past several years, the Council has not been able to meet the 90-day timeframe for adjudication in some cases, resulting in a backlog of appeals at the Council.

Fifth Level of Appeal: Judicial Review in U.S. District Court

A party may request judicial review in Federal district court of a decision by the Council, or an appellant may request escalation to Federal district court if the Council does not render an action by the end of the specified timeframe. A higher minimum amount-in-controversy is required for judicial review (the amount is adjusted annually based on a formula prescribed by statute; and for 2016, the minimum amount-in-controversy for a claim appealed to Federal district court is \$1,500). Parties dissatisfied with the outcome of a Council review have 60 days from the date of receipt of the Council's decision to file an action in Federal district court.

What is the Medicare Appeals Backlog?

In FY 2015, more than 1.2 billion Medicare fee-for-service claims were processed. On initial determination, just 123 million claims (or 10%) were denied. 3.7 million denied claims (3% of all Medicare denied claims) were appealed. HHS has continued its work to strengthen Medicare's program integrity activities to help protect the Medicare Trust Funds for current and future generations. Several factors, including the growth in Medicare claims – partially driven by the aging population – and HHS's continued investment and focus on ensuring program integrity have led to more appeals than OMHA and the Council can process within the contemplated time frames. From FY 2010 through FY 2015, OMHA experienced an overall 442% increase in the number of appeals received annually. In the same time frame, the Council experienced an overall 267% increase in the number of appeals it received annually. However, while the volume of appeals has increased dramatically, funding has remained comparatively stagnant. As a result, as of the end of FY 2015, 884,017 appeals were waiting to be adjudicated by OMHA and 14,874 appeals were waiting to be reviewed at the Council. Under current resources (and without any additional appeals), it would take 11 years for OMHA and 6 years for the Council to process their respective backlogs.



What is causing the Medicare Appeals Backlog?

Expansion of Workload

When OMHA was established in 2005, OMHA began receiving the Medicare ALJ hearing workload that had been conducted by Social Security Administration ALJs, which included Medicare claim and entitlement appeals from the Medicare Part A and Part B programs, and coverage appeals from the Medicare Advantage (Part C) program. In addition, OMHA was tasked with an additional workload of

coverage appeals from the then new Medicare Prescription Drug (Part D) program.

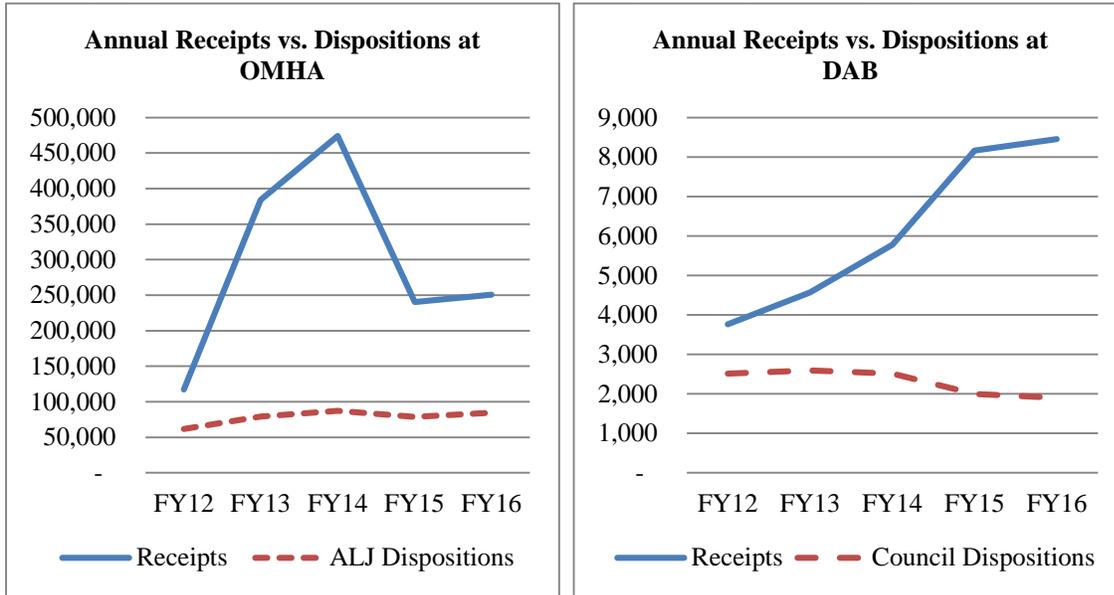


Table 1 FY 2015 Medicare Appeals Data

Medicare Appeals	FY2015 Receipts	FY 2015 Processed	FY 2015 Pending
Level 1: MAC ¹		2,806,752	358,078
Level 2: QIC	561,717	599,291	78,218
Level 3: OMHA ²	240,360	123,765	884,017
Level 4: Council ³	8,162	2,323	14,874

We have identified four primary drivers of the increase in volume:

- 1) Increases 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

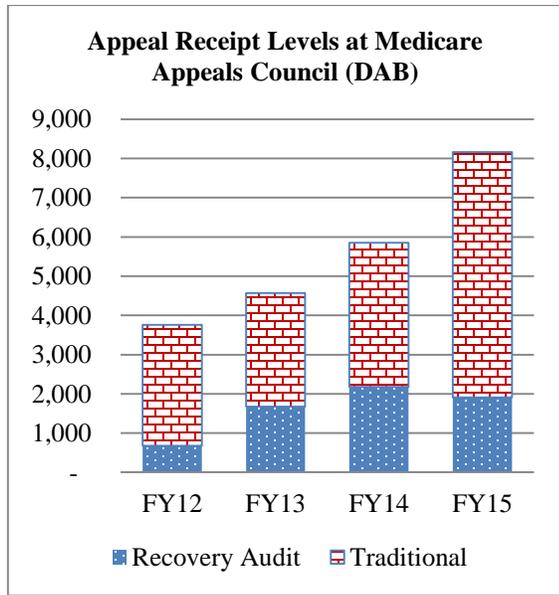
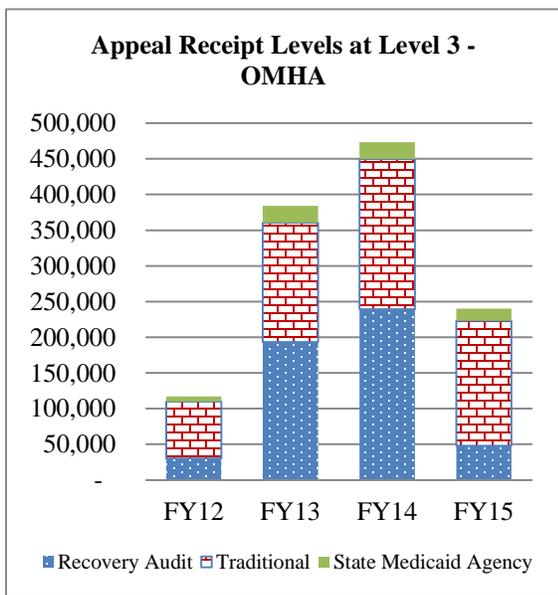
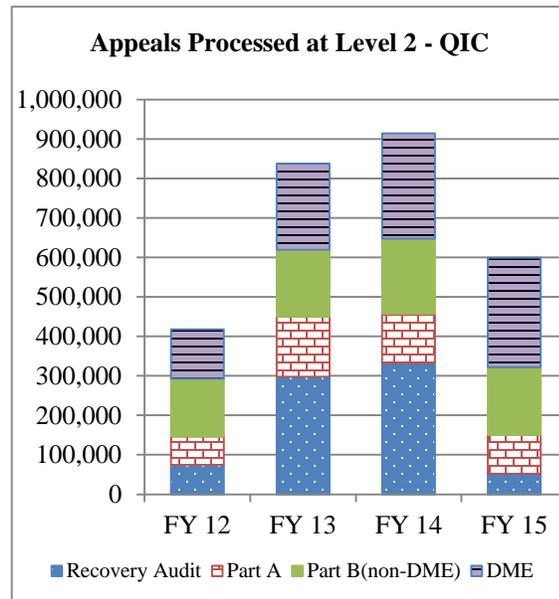
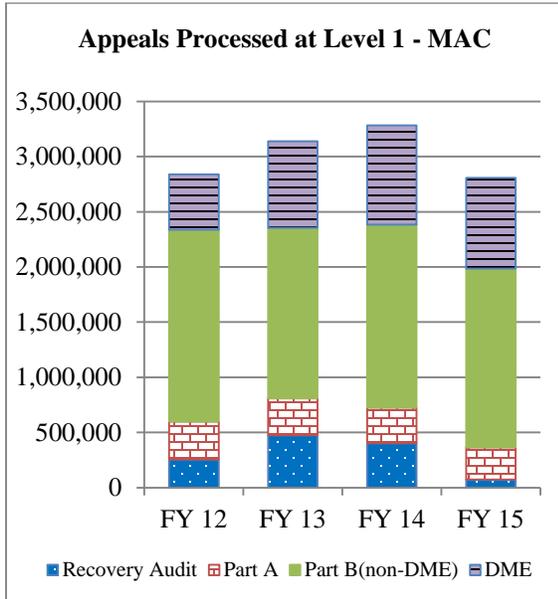
¹ Appeal receipts at MACs may also include re-opened claims, duplicate requests, inquiries, and misrouted requests, in addition to appeal requests. Therefore receipt count at the MAC level is not being used in appeals workload measurement for MACs. Appeals processed in FY 2015 may include appeals received in FY 2014. Some appeals received in FY 2015 may be processed in FY 2016. Appeals pending at MACs and QICs do not represent backlogs. They represent appeals received but not yet adjudicated, i.e., appeals that have not passed the 60-day timeframe for adjudication.

² Appeal receipts include appeals with a Request for Hearing date in FY 2015 and exclude reopened appeals. The number of appeals processed in FY 2015 includes appeals received in prior fiscal years. The number of appeals processed in FY 2015 includes 42,483 appeals closed as a result of the CMS Hospital Settlement. The number of appeals pending includes 215,863 appeals resolved through the CMS Hospital Settlement waiting to be formally removed from the system.

³ The number of appeals processed in FY 2015 includes 322 appeals closed as a result of the CMS Hospital Settlement. The number of appeals pending includes 1,480 appeals resolved through the CMS Hospital Settlement waiting to be formally removed from the system.

4) National implementation of the Medicare Fee-for-Service Recovery Audit (RA) Program.

Although the emergence of appeals from the national Recovery Audit (RA) program (instituted in 2010 pursuant to statute) has contributed to the increasing workload, the traditional Part A and Part B workloads are also increasing and contributing to growth in appeals, and subsequently the backlog. This expansion of the workload also increases the number of appeals that reach the Council.⁴



⁴ Traditional workload of Part A and Part B beneficiaries, and provider and supplier appeals of denials by payment contractors and traditional program integrity contractors

⁵ Recovery Audit data for the Medicare Appeals Council is not always captured at intake.

CMS's Continued Investment and Focus on Ensuring Program Integrity

Because CMS is charged with protecting against inappropriate payments that pose a risk to the Medicare Trust Funds, CMS contracts with claims review contractors to perform analysis of Medicare Fee-for-Service claims data in order to identify atypical billing patterns and to identify inappropriate payments. CMS continues to enhance medical review efforts, both on a prepayment and post-payment basis, and has encouraged increased provider feedback processes, such as one-on-one education and more detailed review results notifications, in an effort to increase proper billing. CMS also takes steps to refine and improve coverage policies and documentation requirements to protect against inappropriate payments where data analysis uncovers vulnerabilities to the Medicare Trust Funds. The result of these increased program integrity efforts and additional scrutiny of Medicare claims has been an increase in the number of appeals. While the growth of Recovery Audit appeals has contributed to the increasing workload, between FY 2010 and FY 2015, OMHA's traditional workload (non-Recovery Audit related, non-State Medicaid Agency appeals) increased 316%. A portion of this traditional workload increase is attributable to these CMS efforts to strengthen the integrity of the Medicare program.

Increases in the Medicare Population

Beginning in 2011, Medicare began experiencing a large increase in the number of new beneficiaries as members of the "baby boom" generation reached 65 and became eligible for Medicare. This, coupled with recent increases in the number of younger disabled individuals enrolling in Medicare, and beneficiaries living longer, has caused increases in the Medicare services provided. This increase in the number of Medicare claims has had a commensurate impact on the number of potential denials of payment and has led to increased appeals of disputed claims. While these increases in the number of appeals were expected, funding to adjudicate them has remained comparatively stagnant.

Adjudication Capacity

Funding for adjudication appropriated annually by Congress has not kept pace with the increase in the number of appeals received. From FY 2010 to FY 2015, OMHA's annual appeals workload grew by 442% while there was little increase in the average number of ALJs since appropriated funds remained relatively flat. In FY 2016, OMHA's total annual adjudication capacity totaled approximately 85,000 appeals. Similarly, the Council's annual appeals workload grew by nearly 2,000% from FY 2009 to FY 2015. In FY 2016, the Council's total annual adjudication capacity totaled approximately 2,600 appeals.

OMHA Appeals Data	FY 2012	FY 2013	FY 2014	FY 2015
Annual Appeal Receipts	117,068	384,151	474,063	240,360
Annual Appropriation (Enacted)	\$72,011,000	\$69,444,000	\$82,381,000	\$87,381,000
Annual Adjudication Capacity	65,000	65,000	72,000	75,000
Disposition	61,528	79,377	87,337	121,339

Provider Representation and Industry Advocates

HHS is aware of two elements of the existing appeals structure that appear to contribute to a growing sense among some appellants and their representatives that appealing every claim is a good business practice. First, the absence of filing fees in the administrative appeals process fosters the notion in the provider appellant community that there is a low risk and potentially high reward associated with pursuing appeals regardless of their merit. For example, of the more than 20,000 appellants that filed appeals with OMHA in FY 2015, including approximately 5,000 individual beneficiaries, five appellants filed over 40% of the appeals (over 97,000 appeals). In addition, at the QIC level about 10% of the appeals filed are for claims with billed amounts of \$50 or less.

Second, the minimum amount in controversy required for an ALJ hearing (currently \$150) is substantially lower than the amount required for judicial review (currently \$1,500). This amount-in-controversy represents a very low barrier for access to the ALJ hearing process and potential review by the Council. Since 2012, there has been a marked increase in companies specializing in the handling of Medicare appeals, fueling increases in appeal filings. Similarly, we observe several companies generating a significant portion of the appeals backlog. Four Durable Medical Equipment (DME) providers and one state Medicaid agency filed 51% of appeals at the ALJ level in the first quarter of fiscal year 2015. At the QIC level, three DME providers filed 35% of all DME QIC appeals in 2015 as compared to 12% in 2012. This suggests that some providers find repetitive appeals good business practice.

What is the current status of the Medicare Appeals Backlog?

At Levels 1 and 2, CMS is currently meeting its statutory time-frames to process appeals and is not experiencing a backlog.

At Level 3, OMHA was receiving more than a year's worth of appeals every 18 weeks at the end of FY 2015. As of the end of FY 2015, the pending workload at OMHA exceeded 880,000 appeals while annual adjudication capacity was approximately 75,000 appeals.

At Level 4, the Council is currently receiving more than a year's worth of appeals work every 11 weeks. As of the end of FY 2015, the pending workload at the Council exceeded 14,000 appeals while annual adjudication capacity was approximately 2,300 appeals.

Because beneficiaries are OMHA's and the Council's most vulnerable appellants, their appeals are prioritized and handled as quickly as possible.

What is HHS doing to address the Medicare Appeals Backlog and Improve the Medicare Appeals System?

HHS has a three-pronged strategy to improve the Medicare Appeals process:

1. Invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog.
2. Take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process.
3. Propose legislative reforms that provide additional funding and new authorities to address the appeals volume.

The FY 2017 President's Budget for OMHA requests \$250 million, which represents a \$142.6 million increase over the FY 2016 funding level of \$107.4 million. The request includes \$120 million in budget authority and \$130 million in program level funding from pending legislation to address the backlog of Medicare appeals. The funding request would allow OMHA to hear more Medicare appeals than ever before by increasing adjudication capacity by 100,000 to 120,000 appeals annually and establishing five new field offices.

The FY 2017 President's Budget for DAB requests \$18.5 million, which represents a \$7.5 million increase over the FY 2016 funding level of \$11 million. The request provides funding for 42 new employees needed to handle the Council's growing backlog of Medicare claim appeals.

HHS has undertaken, and continues to explore, new, administrative actions expected to have a favorable impact on the Medicare Appeals Backlog. These examples illustrate the types of administrative actions underway:

- **Administrative Settlement for Certain Hospitals to Resolve Appeals of Patient Status Denials** – CMS created an administrative agreement process under which an eligible hospital could submit a settlement request for review by CMS. If approved for participation, a hospital would receive timely partial payment for its eligible claims in exchange for withdrawing the associated appeals.
- **OMHA Settlement Conference Facilitation** – Settlement conferences allow for an alternative dispute resolution process conducted by trained OMHA mediators that brings appellants and CMS together to discuss administrative resolution of a group of pending appeals. As of May 12, 2016, OMHA has facilitated the settlement of 4,245 appeals for 16 appellants through this initiative – the equivalent of more than four ALJ teams' annual workload. In addition, OMHA is processing expressions of interest from 50 additional appellants.
- **Prior Authorization** – Under these demonstration programs and models, Medicare and its contractors review requests for prior authorization of power mobility devices, repetitive scheduled non-emergent ambulance transport, and hyperbaric oxygen prior to payment, with the goal of, among other things, reducing the number of denials due to improperly documented claims. Additionally, CMS recently finalized a prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- **DMEPOS Discussion Demonstration** – CMS is engaging in education and outreach at the QIC level with providers and suppliers of a select set of DMEPOS items and services to encourage the submission of more accurate Medicare claims that can be paid on initial submission. As part of this engagement, suppliers have the opportunity, through a telephone discussion with the QIC, to discuss eligible pending claims on appeal, submit additional documentation to support their claim, and receive feedback and education on CMS policies and requirements. Based on discussions with the supplier, the QIC may also reopen some of its prior unfavorable decisions on claims similar to those selected as part of the discussion process that are pending on appeal at OMHA, which may result in the resolution of additional appeals pending at OMHA.
- **On-the-record Adjudication** – Under this OMHA program, in cases where the appellant has waived its right to an oral hearing and requested that the merits of the case be decided on the

existing record, an OMHA senior attorney reviews the record and drafts a recommended decision, which an ALJ reviews and issues if he or she concurs.

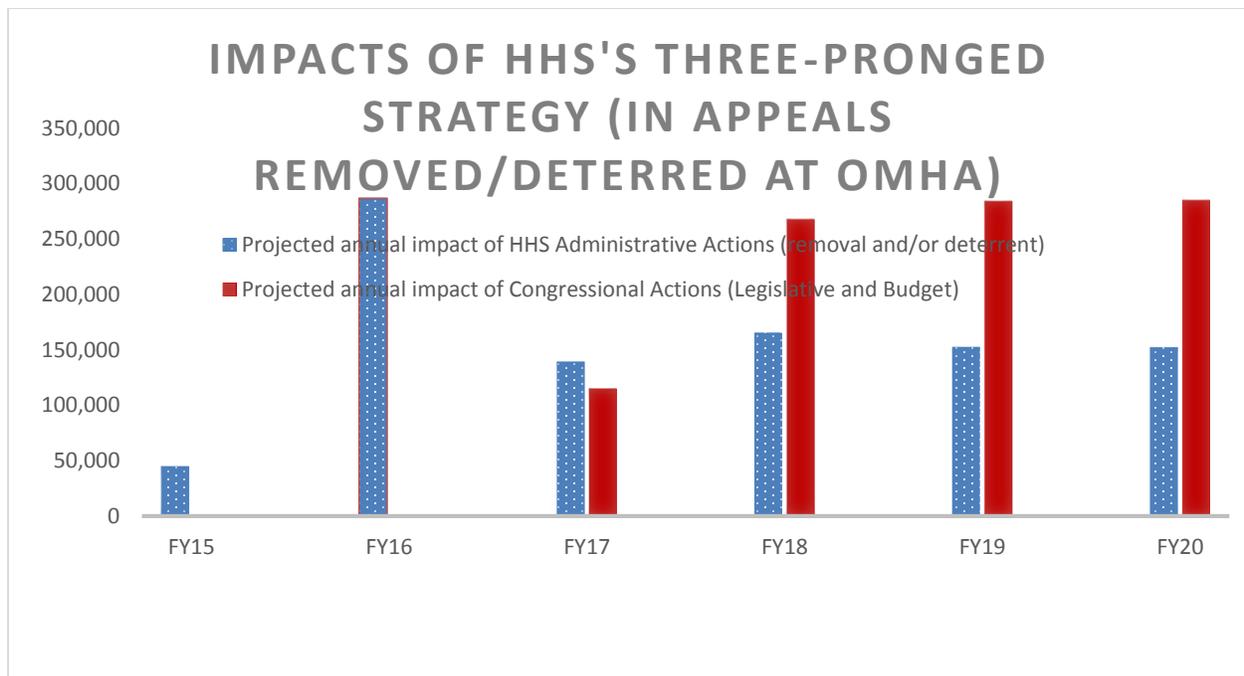
- **Medicare FFS Recovery Audit Program Contract Modifications** – CMS plans a series of changes to the Recovery Auditor contracts that are expected to decrease the number of Recovery Audit-identified claims that enter the Medicare appeals system.

The FY 2017 President’s Budget request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA. These examples illustrate the types of legislative proposals included in the budget:

- **Provide OMHA and DAB authority to use Recovery Audit Contractor collections** – This proposal allows Recovery Audit program recoveries to fully fund Recovery Audit Contractor-related appeals at OMHA and DAB.
- **Establish a Refundable Filing Fee** – This proposal institutes a refundable filing fee for Medicare Parts A and B appeals for providers, suppliers, and State Medicaid agencies, including those acting as a representative of a beneficiary, and requires these entities to pay a per-claim filing fee at each level of appeal. Fees will be returned to appellants who receive a fully favorable appeal determination.
- **Expedited Procedures for Claims with No Material Fact in Dispute** – This proposal allows OMHA to issue decisions without holding a hearing if there is no material fact in dispute.
- **Increase Minimum Amount-in-Controversy for ALJ Adjudication of Claims to Equal the Amount Required for Judicial Review** – This proposal increases the minimum amount in controversy required for an ALJ hearing to the same amount required for judicial review (\$1,500 in calendar year 2016). This allows the amount at issue to better align with the amount spent to adjudicate the claim, and reserve ALJ hearings for more complex and higher amount-in-controversy appeals. Appeals not reaching the minimum amount-in-controversy will be adjudicated by a Medicare Magistrate.
- **Establish Medicare Magistrate Adjudication for Claims with Amount-in-Controversy Between Current and Revised ALJ Amount-in-Controversy Threshold** – This proposal allows OMHA to use Medicare Magistrates for appealed claims between the current and revised minimum amount-in-controversy threshold for an ALJ hearing (at least \$150, but below \$1,500 using calendar year 2016 amounts, and updated annually).
- **Remand Appeals to the Redetermination Level with the Introduction of New Evidence** – This proposal remands an appeal to the first level of appeal when new documentary evidence is submitted into the administrative record at the second level of appeal or above. This proposal incentivizes appellants to include all evidence early in the appeals process and ensures the same record is reviewed and considered at subsequent levels of appeal.
- **Sample and Consolidate Similar Claims for Administrative Efficiency** – This proposal allows the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques. Additionally, this proposal authorizes the Secretary to consolidate related appeals into a single administrative appeal at all levels of the appeals process.

What is the expected impact of the three-pronged strategy to reduce the Medicare Appeals Backlog?

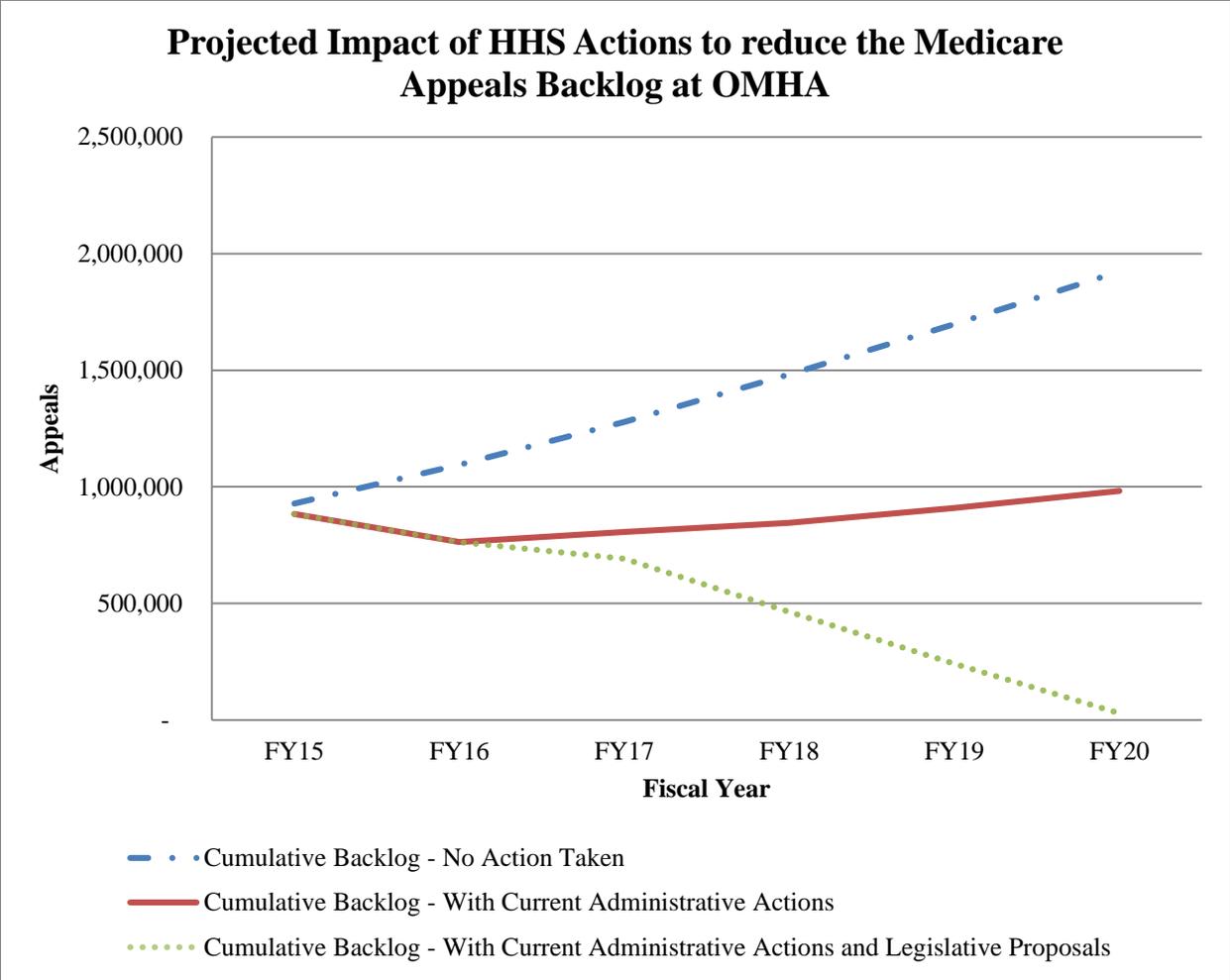
Based on projected impacts of the current administrative actions, and the proposed funding increases and legislative actions outlined in the FY 2017 President’s Budget, HHS projects that the backlog would be just 50,000 appeals by the end of FY 2020 and would be eliminated by FY 2021.



Without the administrative actions outlined above, HHS estimates that the backlog of appeals pending at OMHA would exceed 1.9 million by the end of FY 2020.

Based on the projected impacts for all CMS and OMHA administrative actions currently being implemented, the backlog is expected to be approximately 1 million appeals by the end of FY 2020. However, this is nearly 50% less than what would have been pending if these administrative actions were not taken.

Increases in adjudication capacity at OMHA will result in more OMHA decisions being issued and likely lead to a substantial increase in appeals to the Council, the next level of appeal, even if the rate that parties appeal OMHA decisions to the Council remains the same. Such an increase in requests for Council review without a corresponding increase to the Council’s adjudication capacity will add to the Council’s growing backlog. Simply stated, as administrative actions, pending legislative proposals, and increases in funding result in increased dispositions at OMHA, considering the rate at which cases are appealed to the Council, the increased volume of OMHA dispositions will result in a flood of appeals flowing to the Council for review. If Council disposition capacity remains flat, this volume of new receipts will result in an even larger backlog of appeals at the Council.



Helpful Terms

Amount-in-Controversy: The threshold dollar amount remaining in dispute that is required for an ALJ hearing or judicial review. The amount-in-controversy is updated annually by the percentage increase in the medical care component of the consumer price index for July 2003 to the July preceding the calendar year involved.

Appeal: The process used when a party (for example, a beneficiary, provider, or supplier) disagrees with an initial determination or a revised determination for Medicare payment or coverage of health-care items or services.

Appellant: A person or entity filing an appeal.

Determination: A decision made to pay in full, pay in part, or deny a claim.

Recovery Audit Program: A program created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers under fee-for-service Medicare programs.