Significance and Implications of the Delays in the Assignment of Administrative Law Judges in Medicare Part B Appeals

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In December and January 2014, the U.S. Office of Medicare Hearings and Appeals (OMHA) began notifying providers that it was delaying the assignment of appeals to Administrative Law Judges (ALJs) that were received on or after April 2013. In mid-February 2014, the Chief Administrative Law Judge held an “Appellate Forum” in Washington, DC to explain in detail their decision to delay assignment of appeals, the causes and potential solutions and what appellants should consider doing now in light of these decisions. OMHA jurisdiction includes all pre and post payment Part B claims including coding and/or claim audits by MACs, RACs, ZPICs and Medicare Advantage.

What has been delayed?

The chart below summarizes the Medicare Part B appeal process:

![Medicare Part B Appeal Process Chart]

- Critical to know that recoupment by the MAC occurs on Day 41 (unless the 1st appeal is filed in 30 days) even though there are another 70+ days to appeal.
- **AIC=Amount in Controversy
- ALJs in mid-Atlantic region are > 1 yr. behind in scheduling hearings according to the Report on Medicare Compliance, 6/24/13 at 4.
The first two steps in that process, referred to as “Redetermination” and “Reconsideration”, have not been delayed as these steps are taken prior to an appeal to the ALJ (Level 3). The assignment of a case to an ALJ and the request for a hearing for appeals received on or after April 2013 have been delayed for up 28 months. Exceptions will be made for appeals by beneficiaries. The delay in assignment of an ALJ will then also delay any appeals to the Dept. Appeals Board (Fourth Level) or to the US District Court (Fifth Level). Once the ALJ is assigned, the wait time until the appeals hearing is currently exceeding six (6) months. According to OMHA figures, the average total processing time for appeals (Medicare Parts A, B, C and D) is 329.8 days. “Justice delayed is justice denied” is an old phrase but appropriate for the current state of the ALJ process.

Causes and Initiatives to Address Delays

Part B appeals have grown significantly (in addition to those filed under Medicare Parts A, C (Advantage) and D) since 2009 with the largest increases in FY 2012 vs. 2013—with the total for all appeals almost tripling in that one year. The expansion of post payment audits by RACs, pre-payment reviews by MACs and expansion of the ZPIC/PSC activity related to suspected “fraud or abuse” is cited as factors. For example, the Mid-West Regional Office of OMHA has 480,000 appeals awaiting assignment to an ALJ.

During its February “Appellate Forum”, the OMHA explained several initiatives to reduce the appeals backlog and to increase efficiency. The “appellant portal” is under development that would allow appellants to track their appeal status, ALJ assignment and deadlines via secure website and is expected in the spring 2014. The Office explained that fully operational
electronic appeal functionality (the “electronic case adjudication and processing” (ECAPE) will be developed but not fully implemented until spring 2015. Currently the appeals process appears to be largely a paper-based system with limited electronic filing or tracking capabilities. Finally, the OMHA explained it is considering “mediation”, e.g. informal and non-binding discussions between appellants and payors, and “fast track” review of simple cases by OMHA attorneys.

**HHS Projects More Than 1 Million Appeals Are Backlogged**

According to *Part B News* (June 20, 2014), the delays for an assignment for an ALJ will now be approximately three (3) years as of the end of the federal government’s fiscal year Sept. 30, 2014. The article cites that as of May 22, 2014 the American Hospital Association (AHA) filed suit in federal court alleging that the ALJ delays violate federal law, with individual hospitals joining the AHA as plaintiffs and alleging millions of dollars tied up in the ALJ delays.

If a provider believes that he/she has grounds for an appeal, what should be done given the significant delays for an assignment of an ALJ?

First, as indicated in the appeals chart above (see enclosed), physicians should file a Level 1 appeal (Redetermination) within 30 days of receipt of the RAC or MAC letter informing you of their audit. The recoupment process by which the MAC will recoup the claims under appeal against future payments will be suspended by the filing of the request for Redetermination but only if it is filed in the first 30 days. While this has always been a best practice, it is even more critical now given that if the recoupment occurs before the Level 1 appeal is filed. The 28-month delay in assignment of the ALJ plus the 6 month backlog could mean waiting over 3 years before the ALJ restores payment back to the provider.
Second, physicians may submit all supporting documentation including clinical descriptions of the patient care, narrative descriptions of the E/M code choice, e.g. explain how the differential diagnosis impacted the medical decision making, and any other authoritative support at the Level 1 Redetermination appeal. Physicians can then create the file that they would use before the ALJ at the initial stages of the appeal and should not resubmit the same documents at each of next stages of appeal. According to OMHA, resubmission of case file documents from the lower levels of appeal to subsequent appeals levels is one factor in the delays—simply confirm at each stage of the appeal that the next level appeal has the full case file and supporting materials from the earlier appeal—this should occur anyway but confirm the same via email or letter.

Finally, OMHA is recommending that multiple beneficiaries may be included on the same appeal where the claims present similar facts or findings (consolidation), e.g. whether CPT 93010 was appropriately coded based on the documentation and billed, by attaching a spreadsheet of the beneficiaries and dates of service in question. Physicians should also include a cover letter explaining why they believe the appeals can be consolidated and contact information if there are questions.

In short, physicians must submit full supporting materials for the Level 1 appeal to cut off the recoupment and consolidate similar appeals together as noted above. It is important to communicate with providers regarding these delays and track the progress of all appeals—albeit delayed as it may be for the next several years while the OMHA takes steps to resolve the backlog and become more efficient through technology.

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