If a provider or beneficiary receives an unfavorable Medicare claim determination, they have the option to either correct the claim or appeal the decision. There is no cost associated with filing a Medicare claim appeal. Cases are reviewed by Medicare policy experts to ensure the claim in question adheres to program rules. However, at the third level of appeal – the Administrative Law Judge (ALJ) level – judges are allowed to decide cases at their discretion and are not required to adhere to Medicare policy. Given that some appeals denied at the two lower levels are then sustained at the ALJ level, providers have seized upon this potential loophole and flooded the system with appeals, contributing to a large backlog of 750,000 claims.

**What Created the Medicare Appeals Backlog?**

According to the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), “wide interpretation” of Medicare policy taking place at the ALJ level of appeals drew the attention of providers who then flooded the appeals process in the hope of achieving a reversal of their claim denials. The appeals backlog was then compounded by the overall increase of both provider and beneficiary appeals due to the growth of the Medicare system and by understaffed resources at the ALJ level.

All other levels of appeal strictly adhere to Medicare policy, but ALJ’s are permitted to determine cases at their discretion, without the requirement of adherence to Medicare policy. This inconsistency at the ALJ level led to the surge in “frequent filers,” providers who appeal every denied claim in defiance of Medicare policy. For example, the OIG found that in 2012 providers filed six appeals each on average, with at least 96 providers filing at least 50 appeals, and one provider filing over 1,000. These accounted for nearly one-third of all ALJ appeals that year.

Additionally, in 2015, Chief ALJ Nancy Griswold testified before Congress that “51% of the incoming appeals have been filed by the same five appellants.”

**Providers Lay Blame to Create a Distraction**

With many appeals then being sustained at the ALJ level, providers and their advocacy groups began claiming that Recovery Audit Contractors inappropriately deny claims necessitating the increase in appeals to the ALJ level. This is false. Recovery Audit Contractors have maintained an accuracy rate greater than 95% as determined by an independent validator. HHS recently shared that only 9.5% of Medicare appeals were RAC related in FY2016 and only 14.1% in FY2015. HHS has also stated unequivocally that the RAC program “simply was not, and is not, the primary source of the [Medicare appeals] backlog.”

Refuting claims by the hospital industry that the Recovery Audit Contractor (RAC) Program is the cause of the claim review backlog within the Medicare appeals system, HHS also revealed:

- Appeals from State Medicaid agencies continue to make up a significant portion of the backlog, and
- New HHS policies have already begun to work, reducing the backlog by 26%.

**Appeal Receipts Levels at Level 3 - OMHA**

![Appeal Receipts Levels at Level 3 - OMHA](chart.png)

Source: HHS Primer, The Medicare Appeals Process
American Hospital Association vs. Secretary Burwell

Interestingly, the American Hospital Association (AHA) sued the Secretary of HHS over a lack of timely review of Medicare reimbursement appeals, alleging that HHS was not able to resolve appeals within statutory timeframes due to the backlog. The District Court that heard the original case dismissed it, and urged Congress to take action to fix the backlog. AHA appealed this decision to the DC Circuit Court, and on February 9, 2016, the DC Circuit Court reversed the District Court’s dismissal, sending the case back to the District Court for review. On December 7, 2016, the District Court ruled that HHS has until 2021 to fully clear the appeals backlog.

HHS has already put in place several efforts to address the backlog, which has thus far retired nearly 200,000 cases since litigation began in late Winter 2015. HHS also offered providers two opportunities to settle their backlogged cases, decreasing the backlog by 288,726 appeals. The Settlement Conference Facilitation has also been expanded, adding 11 new facilitators. Most recently, HHS announced a new third settlement for providers, which they estimated would remove another 95,000 appeals from the backlog.

Unfortunately, in early March 2017, HHS officials reported that despite the active efforts in place to reduce the backlog, the department does not have the resources to wipe out pending appeals by the court-imposed 2021 deadline. In a report to the U.S. District Court in the District of Columbia, HHS said that some of their proposed efforts have not been as effective in reducing the backlog as expected, and have seen an influx of more appeals than previously anticipated.

HHS reports that as of March 2017, there are 667,326 pending appeals and projects the number will rise 3% by the end of 2017 to 687,382. That number will eventually rise 46% by the end of 2021 to just over 1 million claims.

HHS recently reopened an initiative to settle pending hospital appeals. But unlike with the previous two settlement offers, providers are showing a lack of interest in settlements, since they expect larger payouts through the broken appeals process.

HHS Makes Changes to the ALJ Level of Appeals

HHS has published a final rule which revises procedures at the ALJ level of appeal. The goal of the final rule is to streamline the appeals process, increase consistency in decision-making and improve efficiency. The final rule took effect on March 20, 2017 and specifically will:

- Permit the designation of particular decisions as precedential to provide more consistency among all levels of appeal, reduce the resources required to render decisions, and reduce appeal rates by providing clarity to appellants and adjudicators;
- Expand OMHA’s available adjudicator pool by allowing attorney adjudicators to decide appeals for which a decision can be issued without a hearing. This change will allow ALJs to focus their efforts on conducting hearings and adjudicating the merits of more complex cases;
- Clarify areas of the regulations that currently cause confusion and may result in unnecessary appeals;
- Create process efficiencies by eliminating unnecessary steps, streamlining certain procedures and requiring appellants to provide more information on what they are appealing and who will be attending a hearing; and
- Address areas for improvement previously identified by stakeholders to increase the quality of the process and responsiveness to customers, such as establishing an adjudication time frame for cases remanded from the Medicare Appeals Council, revising remand rules to help ensure cases keep moving forward in the process, simplifying the escalation process, and providing more specific rules on what constitutes good cause for new evidence to be admitted at the OMHA level of appeal.

### Medicare Appeals: 2017 Primer

<table>
<thead>
<tr>
<th>Level of Appeal</th>
<th>Entity Considering Appeal</th>
<th>Timeframe</th>
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<tbody>
<tr>
<td>1st</td>
<td>Medicare Administrative Contractor (MAC)</td>
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</tr>
<tr>
<td>2nd</td>
<td>Qualified Independent Contractor (QIC)</td>
<td>60 days</td>
</tr>
<tr>
<td>3rd</td>
<td>Administrative Law Judge (ALJ)</td>
<td>90 days</td>
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<tr>
<td>4th</td>
<td>Medicare Appeals Council</td>
<td>90 days</td>
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<tr>
<td>Total for all levels</td>
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<td>Within ~1 year</td>
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Audit and Appeals Fairness, Integrity and Reforms in Medicare (AFIRM) Act

In addition to the work of the HHS to clear the backlog, Congressional action is needed to pass the Audit and Appeals Fairness, Integrity and Reforms in Medicare (AFIRM) Act. Passed by the Senate Finance Committee last year, AFIRM seeks to make urgently needed programmatic changes to further address the cases waiting for review in the appeals process.

The AFIRM Act would ensure active steps are taken to address the backlog by sending claims back to the first level of appeal when new evidence is introduced later in the process. It would also create Medicare Magistrates to perform reviews and render decisions on certain types of cases, and ensure fairness by requiring that all parties involved be notified in advance of a hearing to allow for participation of all stakeholders.

While the AFIRM Act addresses several issues facing the struggling Medicare appeals process, The Council for Medicare Integrity (CMI) recommends some additional safeguards to further promote expediency and prevent future backlogs, specifically:

- Requirements recommended by Congress that ALJs make decisions consistently and in accordance with Medicare policy;
- Inclusion of a filing fee to discourage frivolous appeals, refundable if a provider wins its appeal, as championed by the President's Budget, the HHS Secretary and Chief ALJ;
- Penalties for providers who fail to bill a claim within 3 months of the date of service; and,
- Expedition of claims where no facts are disputed.

The Bottom Line

The Medicare program is in financial peril. Medicare Trustees report that at current levels of Medicare spending, the Medicare Trust Fund will be depleted by 2028 and that in order to sustain the program long term they would need an additional $3 trillion, beginning in 2015.

Over the past four years alone, Medicare has lost more than $166 billion to improper payments. These improper payments stem from provider billing mistakes – simple coding errors, duplicate billing, up-coding and medical services rendered that were not medically necessary – not from intentional fraud, which is accounted for separately. In fact, the Medicare billing error rate has remained above the legally mandated limit of 10% for the past four years, putting the program’s financial future in serious jeopardy.

Based on success in the private sector, Recovery Audit Contractors were mandated by Congress to review post-payment Medicare claims to identify improper payments and recover the misspent funds. This important auditing work has returned more than $10 billion in improper payments to Medicare and has been credited with prolonging the life of the program by two full years.

Unfortunately, due to provider pressure about auditing, the Centers for Medicare & Medicaid Services (CMS) has greatly scaled back the RAC program – actively preventing the recovery of the more than $40 billion annually misspent from the Medicare program.

Congressional support is greatly needed to provide HHS with the resources they need and to pass the AFIRM Act to secure additional safeguards that will get the Medicare appeals process back on track.

All Medicare stakeholders must champion the renewal of a strong recovery auditing effort that will continue to return billions of dollars in improper payments to the Medicare Trust Funds each year.

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4 December 2016: FY2015 RAC Report to Congress