American Orthotic & Prosthetic Association

Restore Due Process Rights & Proper Administrative Law Judge Timeframes

Background

There are five levels in the Medicare claims appeal process and the Administrative Law Judge (ALJ) is the third level; and the Office of Medicare Hearings and Appeals (OMHA) is the entity responsible for overseeing the ALJs. The ALJ level allows a supplier/beneficiary/provider the opportunity to present their appeal to a person who will independently review the materials provided and render a new decision in accordance with the law and not render a decision based on Medicare policy; and according to the HHS-OIG, ALJs reversed prior-level decisions and decided fully in favor of appellants in 56 percent of appeals in FY 2010. The Cromnibus Bill also stated that: "Information received from the Office of Medicare Hearings and Appeals (OMHA) indicates that about 50 percent of the estimated 43,000 appeals were fully or partially overturned at its level".

Current ALJ/OMHA Statistics

- In January 2012 the weekly average of requests for appeals filed was 1,250. In December 2013 the weekly average rose to 15,000
- In December 2013 the OMHA estimated the backlog of pending appeals grew from 92,000 claims to over 460,000 claims; and it was estimated to reach nearly 1,000,000 by the end of 2014
- Requests for ALJ hearings in fiscal year 2011 totaled 59,600. In fiscal year 2013 the total was 384,151 and in fiscal year (through June) 2014 the total was 395,000. At present, there are approximately 1 million claim appeals awaiting an ALJ hearing and decision
- In FY14 (as of June) 227,000 appeals filed with the ALJs were the result of RAC audits
- The number of appeals decided by an ALJ in fiscal year 2011 was 53,868 in fiscal year 2013 the number was 79,372 and in fiscal year (through June) 2014 the total was 87,266
- OMHA anticipates that assignment of requests for ALJ hearings may be delayed for up to 24 months
- As of October 2014 OMHA was still assigning appeals from 2013.
- Average processing time for an appeal decided by an ALJ in fiscal year 2015 is 547 days, compared to 94.9 days in fiscal year 2009; 121.3 days in fiscal year 2011, 220.7 days in fiscal year 2013 and 414.8 days in fiscal year 2014

This increased workload, number of appeals being filed, and the backlog being created is directly related to the increase in audit activity by Medicare and its contractors over the last

few years. In an attempt to work through the backlog the OMHA has temporarily suspended the assignment of any new ALJ hearing requests as to claims appeals by providers (no interruption in assigning patient/beneficiary claims) and anticipates that assignment of requests for ALJ hearings may be delayed for up to 24 months, in essence halting the appeal process for up to two years. Before OMHA enacted the temporary suspension in assigning hearing dates for new appeals, O&P providers have already been forced to wait up to 26 months to get their appeal heard by the ALJ. This suspension will almost certainly make the wait even longer (perhaps 4 years or longer), in violation of the law which stipulates that a provider is entitled to an ALJ decision within 90 days of the date the provider files an appeals.

However, this temporary delay doesn't halt all aspect of the audit process or provide any solace or break to suppliers/providers. During this two year delay any money CMS previously paid on claims, now denied through audits, is being recouped, with interest, and held by Medicare until the appeals process is completed. So, even though CMS through the OMHA has halted the appeals process they have not halted their collection activities. Also as this temporary delay drags on the audit appeals are continuing to pour in causing the supplier/provider to file more appeals; increasing the ALJ backlog and placing a finical burden on the healthcare provider.

Recommendation

Congress emphasized the importance of quickly processing Medicare appeals when it passed the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA), which included a statutory requirement that ALJ's issue decisions no more than 90 days from the date the appeal request filing date.

CMS/OMHA continues to exceed the timeframe established by the SCHIP statute and leaves Medicare providers without an adequate avenue of redress against CMS and its contracted auditors' (many of whom are compensated on a 'bounty' system) over payment denials of individual claims. Moreover, the growing backlog in provider appeals continues to put financial pressure on providers, many of whom operate small businesses that cannot afford to have cash flows endlessly held up in the appeal process.

Please ask your legislators to both communicate to acting CMS Administrator Slavitt that CMS/OMHA continue to violate their statutory requirement to avail an ALJ hearing within 90 days, and compel them to suspend any new audits, including any overpayment recoupments, and to embrace the legislative proposal to delay the recoupment date for audits until after the ALJ hearing, at least until such time as CMS/HHS/OMHA demonstrate that they are complying with the 90-day statutory time frame for an ALJ decision—it will both save the government money and will keep small business providers out of bankruptcy, their current plight as they surrender their money and wait in line for years for an appeal, all the while often unable to meet their bills.

Justice Delayed is Justice Denied

For more information contact the American Orthotic & Prosthetic

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