The Metropolitan Corporate Counsel®

www.metrocorpcounsel.com

February 2013 | Volume 21, No. 2

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Office Of Inspector General Report Focuses On Medicare Administrative Law Judge Appeals Process

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When a health care provider receives notice of claimed overpayments by Medicare from a Recovery Audit Contractor (RAC) or Zone Integrity Program Contractor (ZPIC), the process to challenge such overpayment claims is typically long and arduous. The Level 1 challenge is a request to the Medicare Administrative Contractor (MAC) for redetermination of the claimed overpayments. Barring a result in the provider's favor, the next step, Level 2, is a reconsideration request to the Qualified Independent Contractor (QIC) of the claimed overpayments. While the Code of Federal Regulations requires that Level 1 and 2 reviews be conducted over short periods (e.g., reconsideration within 60 days), these reviews often cumulatively take many months or even years to complete, creating a substantial resource drain on providers along the way, as well as cash flow impairment once recoupment begins. Moreover, the majority of Level 1 and 2 reviews do not garner satisfactory results from the provider's vantage.

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Following a Level 2 reconsideration, the unsuccessful provider may then proceed to Level 3, an appeal to the Office of Medicare Hearings and Appeals (OMHA), and have the provider's challenges heard by an OMHA Administrative Law Judge (ALJ). Here, the provider would have an opportunity to present all evidence provided at Levels 1 and 2, and possibly additional evidence, to an ALJ during a full hearing on the claimed overpayments (typically conducted via video conference). The ALJ must review the evidence and render a de novo determination, meaning that the ALJ is not bound by the determinations of the MAC or QIC at Levels 1 and 2 and must make an independent, new decision on the claimed overpayments, the evidence and the provider's correlating challenges.

The November 2012 OIG Report

The Office of Inspector General (OIG), which is tasked with protecting the integrity of Medicare, Medicaid and other Department of Health & Human Services programs, released Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals (OEI-02-10-00340) on November 15. Therein, the OIG reported that, during 2010, ALJs reversed 56 percent of the Level 2 decisions on appeal before them. For providers, the reported statistics were even higher. Hospitals saw 72 percent of their 2010 appeals result in fully favorable determinations, while 60 percent of practitioner appeals over the same period similarly resulted in fully favorable determinations.

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Providers could be encouraged by these statistics because they demonstrate a high success rate before ALJs, but the OIG report also made a number of recommendations aimed at bringing ALJ decisions more in line with the QICs' reconsideration decisions rendered at Level 2. Those recommendations include:

- develop and provide extensive annual training by the Centers for Medicare & Medicaid Services (CMS) for both the ALJs and QICs;
- institute a filing fee for ALJ appeals;
- implement a quality assurance process to review ALJ decisions;
- determine whether specialization among ALJs would improve efficiency;
- encourage CMS participation in appeals; and
- identify and clarify CMS policies that are interpreted differently by ALJs and QICs.

CMS and OMHA both gave support to many of the OIG's recommendations, including the changes to the standard for the admission of new evidence, the establishment of an ALJ appeal filing fee and the increase of CMS participation in ALJ appeals. However, it is far from given that these or other recommendations will become operative, as OMHA lacks statutory and regulatory authority to clarify CMS policies. Similarly, ALJ specialization may be difficult to achieve, as federal law requires all ALJ appeals be assigned to judges via random lottery. While the report's recommendations appear to be aimed at easing the government's burden in the appeals process, the report does not suggest that any of the appellate victories of providers or beneficiaries giving rise to these statistics lacked merit.

What Is Expected?

Shortly after the OIG issued this report, HHS published its semiannual report to Congress, including its expectation that the OIG will recover $6 billion from providers during the first six months of 2012, up from $4.6 billion in 2011 and $3.8 billion in 2010. Given its aggressive recovery efforts, the OIG will likely continue its campaign to modify the ALJ process and reduce the number of successful ALJ appeals.

In addition, it is difficult to predict how OMHA ALJs may react to this report and the objectives stated or implied therein. Accordingly, it becomes even more important to consider the opportunity presented by a Level 3 evidentiary hearing, which allows the ALJ to consider live testimony from the provider's witnesses as well as expert witnesses. Under limited circumstances, ALJs may also consider new documentation that was not provided during the Level 1 and 2 determinations.

The OIG report notes that ALJs view their role as making the best determination possible and are more likely to admit new evidence if it furthers that goal. While the OIG notes that such a role potentially "eliminates the value of the two previous levels of appeal," providers should take some comfort in the ALJs' statutory mandate to conduct a de novo review and should make the most of the opportunity to have an ALJ decide whether Medicare properly paid claims for care rendered.