Health Law Bulletin

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CMS Completes Rulemaking Related To New Medicare Appeals Process

On September 16, 2009, CMS published final regulations that complete the rulemaking process for the new Medicare appeals process. The new rules took effect for appeals initiated as of May 1, 2005. (Even though CMS is just now finalizing the last rule, they have been operating under the new process since 2005.) If you have not initiated an appeal since then, you may not be familiar with the new rules. There are three components of the new appeals process: consolidation of Part A and Part B appeals into a 5-step process, creation of the Office of Medicare Hearings and Appeals to hear appeals at the administrative law judge level, and a prohibition on recoupment of alleged overpayments in certain situations.

New Consolidated Appeals Process

For appeals prior to May 1, 2005, Part A and Part B providers used separate appeals processes. The Part A process had four steps; the Part B process had five steps. Appeals often took years if the provider pursued the appeal to the higher levels in the process.

There is now one five-step appeals process for all Medicare providers:

- Redetermination—A Request for Redetermination is submitted to your Medicare Administrative Contractor (MAC) (formerly referred to as "carriers" or "fiscal intermediaries"). A provider has 120 days from the date of a final determination to request a Redetermination. The MAC has 60 days to consider the request and render a decision.
- Reconsideration—A Request for Reconsideration is submitted to a "Qualified Independent Contractor" (QIC). The QICs are a new feature of the appeals process. The QIC plays no part in the initial determination. Therefore, they are likely to be more objective in reviewing appeals. A provider has 180 days to file for a Reconsideration, and the QIC has 60 days to make its decision. One important point for the Reconsideration level is that a provider is generally required to provide all written evidence at this level; additional written evidence will not be considered at higher levels, unless the provider had good cause for not submitting the evidence earlier.
- Administrative Law Judge—The ALJ level is the first opportunity for an appealing provider to engage in a person-to-person consideration of the appeal, as opposed to the first two levels, which are based solely on the record and written evidence presented by the provider. A provider has 60 days to request an ALJ hearing. The ALJ has 90 days from the date of the request to hold the hearing and render the decision. This 90-day requirement should streamline the appeals process considerably: The average time for ALJ decisions to be rendered under the prior appeals process was 441 days.
- Medicare Appeals Council—A provider has 60 days to appeal an ALJ decision to the Medicare Appeals Council. This is the final administrative level in the appeals process.

- Federal District Court—A provider who is dissatisfied with a decision by the Medicare Appeals Council has 60 days to file a petition for review in federal district court.

Creation of the Office of Medicare Hearings and Appeals

Prior to the new process, ALJs were employed by the Social Security Administration. In 2005, the Office of Medicare Hearings and Appeals (OMHA) was created within the Department of Health and Human Services, the same agency that administers the Medicare program. OMHA has a headquarters office and four field offices that serve specified areas of the country. ALJ hearings are generally held by telephone or video conference, although a provider does have the right to request an in-person hearing. A provider is allowed to present testimony on his own behalf or present other witnesses at an ALJ hearing.

Suspension of Recoupments Through the Reconsideration Process

Under the old process, Medicare was allowed to begin recoupment of alleged overpayments during the time the provider was appealing that overpayment. The September 16, 2009, regulations implement a provision of the statute that prohibits CMS from recouping alleged overpayments until the QIC makes a decision on the Reconsideration.

The bar on recoupment is a plus for providers, particularly those who depend on their Medicare cash flow to survive. However, CMS did place restrictions on this provision. In order to avoid recoupment, a provider must file its Request for Redetermination (first level) within 41 days of the original determination. The provider must then file its Request for Reconsideration within 60 days of the Redetermination decision. These timeframes are shorter than the timeframes discussed above for the first two levels of appeal. In other words, to avoid recoupment, you have to submit your first and second level appeals more quickly than is required by law. However, if you file a first level appeal after 41 days or a second level appeal after 60 days, the recoupment stops again. Once the QIC makes its decision, the bar on recoupment no longer applies, and Medicare is allowed to begin (or resume) recoupment, even if the provider is appealing further.

Even though the appeals process is now consolidated and presumably more efficient, a provider must carefully consider the decision of whether to pursue an appeal in the first place or to proceed to the next step after an unfavorable decision. If a provider appeals and loses, it will owe interest on any overpayments that have not been recouped. Also, a provider must consider the costs of preparing the appeal and its documentation and the cost of legal fees if the provider uses an attorney to pursue its appeal. The decision of whether to advance an appeal will also depend on the results of the early appeals. If a provider gets most of the overpayment reversed at the first level, it may not be worth it to take the remaining cases to the next level. The decision to appeal is made on a case-by-case basis and should be made in consultation with your attorney.