



AGG Helps Hospice Weather the Perfect Storm of Aggressive Medicare Payment Denials and Administrative Appeal Backlog

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Medicare's implementation of post-payment review through private contractors who are overly aggressive in denying payments, combined with a severe backlog of cases in queue for hearing before an Administrative Law Judge (ALJ), and statutory recoupment of "overpayments" prior to an ALJ decision have combined to create a perfect storm for Medicare providers. This article will explain the Medicare payment, post-payment audit, appeal, and recoupment processes, how flaws in those processes can result in the improper and premature recoupment of millions of dollars in Medicare payments, and how we helped one hospice provider fight back so that it could continue to deliver high-quality care to its patients while it challenges the payment denials through the administrative appeals process.

A. The Flawed Medicare Overpayment Determination and Appeals Process

1. The Medicare Billing Dispute Appeals Process

The United States reimburses Medicare providers with payments through the Centers for Medicare & Medicaid Services (CMS). CMS, in turn, contracts with Medicare Administrative Contractors (MACs) to review, approve, and pay Medicare bills, called "claims," received from health care providers. In practice, when medical providers furnish services to a Medicare beneficiary, the providers thereafter submit a claim for reimbursement to a MAC. 42 U.S.C. § 1395ff(a)(2)(A). MACs are government contractors responsible for processing Medicare claims and making payments. 42 U.S.C. § 1395kk-1(a)(3).

Some claims that are initially paid by MACs are then subjected to a process known as "post-payment review," in which third-party contractors audit, and frequently reverse, MAC payment decisions. The result of audits performed by these contractors, known as Recovery Audit Contractors (RACs) or Zone Program Integrity Contractors (ZPICs) are appealed through the Medicare claims appeals process. These contractors have financial incentives to find overpayments and, perhaps as a result of judgment clouded by these incentives, their claim denials are frequently overturned on appeal.

Appeals of post-payment claim denials are subject to a four-step process, set forth by statute. 42 U.S.C. § 1395ff. The first two steps of the process (Redetermination and Reconsideration) are overseen by CMS; the third (the ALJ Hearing) is overseen by the HHS Office of Medicare Hearings and Appeals (OMHA); and the fourth is overseen by the Departmental Appeals Board (DAB). The third step, an ALJ Hearing, represents the first opportunity for independent review and is the level of the appeals process at which Medicare providers typically have the most success in overturning claim denials. According to a report prepared by the Office of Inspector General of the Department of Health and Human Services, "ALJs reversed prior-level decisions by QICs [Qualified Independent Contractors] and decided fully in favor of appellants in 56% of appeals in FY 2010." See *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals* (OEI-02-10-00340), at 9 (Nov. 2012), available [here](http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf)¹ (last visited Sept. 15, 2015). This does not include "partially favorable" decisions, nor does it include reversals that occur at earlier

¹ <http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf>.

stages of review.

2. The Delay in Obtaining an ALJ Hearing

Because the ALJ Hearing is a provider's first opportunity for independent review and because of the success that providers typically find there, providers understandably are eager to get any payment denials that remain after the first two levels of review in front of an ALJ as quickly as possible. Providers are entitled by statute to an ALJ Hearing and decision within 90 days of a timely request. 42 U.S.C. § 1395ff(d)(1)(A); 42 C.F.R. § 405.1016(a). Enormous increases in the rates of appeal, in significant part by providers challenging inappropriate denials by over-zealous RACs and ZPICs, have caused a massive backlog at the ALJ level of the appeals process. In just two years (2012 and 2013), the backlog of ALJ-level appeals quintupled, growing from 92,000 to 460,000 pending claims. There is a two-year moratorium on assignment of new appeals to an ALJ, and it takes at least three to five years from a timely request to obtain an ALJ Hearing.

3. Statutory Recoupment Pending ALJ Decision.

Notwithstanding the substantial backlog at the ALJ level of administrative review and the likelihood that a significant portion of the alleged "overpayments" will be reversed by the ALJ decision, CMS is permitted (it would argue that it is mandated) to initiate recoupment following the "reconsideration" decision. 42 U.S.C. §§ 1395gg, 1395ddd(f)(2); 42 C.F.R. §§ 405.370, 405.373; *also see* 42 U.S.C. § 1395g(a). Thus, for the three to five years (or more) that a provider awaits an ALJ hearing and decision (which is very likely to reverse a significant portion of the overpayment determinations), the provider will be subjected to recoupment from its Medicare payments until the entire alleged overpayment (plus exorbitant interest, currently at 10.75%) is recouped. The amount of recoupment can easily reach into the millions of dollars. Because the demographics of patients requiring certain services—hospice and skilled nursing, for example—skews to the elderly, Medicare payments may comprise a significant majority of a provider's revenue. Thus, providers face the possibility of having substantial portions of their revenues withheld in satisfaction of an alleged overpayment that, in all likelihood, will be reversed in whole or in substantial part, at the next level of review. Because of the backlog at the ALJ level and the amount of the recoupment, however, many providers cannot survive recoupment.

B. How We Helped a Hospice Provider Fight Back.

1. The Claim Denials Underlying the Threatened Recoupment

In 2014, a ZPIC requested medical records from a hospice as the beginning point for a review. This review was not the result of the ZPIC identifying any aberrant billing patterns for the hospice. In fact, the hospice had been informed by its MAC that, because its billing and patient metrics are so optimal, it would not have been selected for any review.

Nevertheless, the ZPIC conducted two separate, but related, reviews. The ZPIC's reviews were based exclusively on retroactive records reviews, without any communications with or input from the hospice physicians who had actually seen and treated the patients or the patients' own physicians who had certified and recertified the patients' need for hospice services. The first set of claims reviewed resulted in an alleged overpayment determination of approximately \$112,000. The second set of claims reviewed was alleged to be a statistical sample of claims involving one hundred (100) claims for 95 patients. This review, following certain reversals during the first two levels of administrative appeal, resulted in an alleged overpayment in the sample reviewed of approximately \$128,000, which was then extrapolated (using an untested, flawed, and invalid methodology) to a demand of over \$8,600,000. On September 9, 2015, after completion of the first two levels of administrative appeal, the hospice submitted a request for an ALJ Hearing to challenge all of the individual medical necessity determinations as well as the statistical methodology.

2. Consequences of Immediate Recoupment

CMS indicated that it intended to begin recoupment of 100% of the hospice's Medicare receivables after September 18, 2015, and to continue recoupment until 100% of the alleged overpayment, plus interest, had been collected. As with many hospices, Medicare payments represent approximately 80% of the hospice's overall revenues. Immediate recoupment of 100% of its Medicare payments would have been immediately crippling.

Beyond the harm to the hospice, its patients and employees would have been harmed. Its terminally-ill patients and family members, most of whom are elderly and disabled, would have been particularly adversely affected by the closure. They would need to find new hospice providers and would then need to become acclimated to new caregivers. It was doubtful that the other hospice providers in the area would have been able to accommodate all of the hospice's patients. As a result, patients may have been forced to leave their families and community and be placed elsewhere in the state or go without the hospice care they had chosen and that their attending physicians had certified they needed. The hospice had patients who were receiving care in its inpatient hospice facility (the only one in the area) and who would have needed to be transferred to another non-hospice inpatient facility, most likely a nursing home. If forced to close, the hospice's 200 employees would have been forced out of work as well. Because of the backlog and delay in obtaining an ALJ Hearing, all of this catastrophic and irreparable harm would have occurred before the hospice received its first opportunity for full and fair review by an independent party, and even though such review results in reversals of the claim denials approximately 70% of the time.

3. The Court Action to Prevent Recoupment

Armed with the facts above, we filed a Complaint and a Motion for Temporary Restraining Order in federal court seeking to prevent recoupment pending completion of the administrative review procedures, including the ALJ Hearing.² We argued, among other things, that the review process the hospice had received up to that point was so systemically flawed that it was constitutionally insufficient to support a crippling recoupment. The court granted a Temporary Restraining Order,³ which temporarily prevented any recoupment and set the matter for a hearing on the hospice's motion for a preliminary injunction.

At the hearing on the preliminary injunction, we were able to show that the hospice had not received sufficient procedural due process to protect it from an erroneous deprivation of its property under *Mathews v. Eldridge*, 424 U.S. 319 (1976). We were able to demonstrate through government reports that the only pre-recoupment administrative review that the hospice had received up to that point was so systemically flawed that approximately 70% of the overpayment determinations that remain after these reviews are reversed at the next level of review. In addition, we established that the overpayment determinations, as well as the statistical methodology used, were likely to be reversed in an ALJ hearing.⁴ We showed that, due to the backlog of ALJ appeals, the hospice would not receive an ALJ decision within 90 days of request as required by statute, but would instead be forced to wait at least three to five years for a decision. Finally, we demonstrated the catastrophic harm that would result to the hospice if recoupment were allowed to proceed as well as the harm to the hospice's patients and the community at large if the hospice were forced to close.

At the close of the hearing, the Court implored all parties to reach a resolution that would permit the hospice to remain open continue to serve its community while it pursued its administrative appeals. Ultimately, CMS agreed to a significantly reduced payment schedule that was more reflective of the likelihood that the underlying overpayment determinations would be reversed and, most importantly, that was sufficiently manageable for the hospice to allow it to continue to deliver high-quality services to its hospice patients while it awaits its ALJ hearing.

² Notably, we did not ask the Court to decide or to reverse any of the overpayment determinations, to make any rulings with respect to the validity of the statistical methodology underlying the extrapolation, or otherwise to usurp the role of the ALJ. We made clear that the sole purpose of our filings was to permit the administrative review process to run its course, not to avoid or disrupt that process. This is important because the Court's jurisdiction over Medicare appeals is limited.

³ A copy of the Temporary Restraining Order can be found by clicking here.

⁴ Again, we did not ask the Court to usurp the ALJ's role and actually decide any of the overpayment determinations or the validity of the extrapolation methodology. However, we did present sufficient expert testimony that the Court could safely conclude that it was likely that many of the overpayment determinations would not survive ALJ review. For example, we showed the Court that the contractors' determinations of supposedly medically unnecessary hospice services included multiple patients who were admitted to hospice and passed away within ten days of admission. In addition, we showed that the extrapolation methodology was newly-created and had never been published in a statistics journal and had never been peer-reviewed and presented expert testimony that the methodology and the implementation of the methodology were both flawed.

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