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Trends in Challenges to Medicare Payment Disputes: Always Pro-Provider?

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Although the Medicare Modernization Act of 2003 outlined what initially appeared to be a more streamlined appeal process for disputes over Medicare payments, the introduction of Recovery Audit Contractors (RACs), Zone Payment Integrity Contractors (ZPICs) and Unified Program Integrity Contractors (UPICs) has resulted in an administrative process with three to five year delays in adjudicating claims, which can be a financial hardship for providers. Fortunately for such providers, within the last year, several federal courts have been willing to revisit the issue of procedural due process claims. Indeed, district courts in Texas, South Carolina, and Florida have issued rulings on whether a provider may enjoin the Centers for Medicare & Medicaid Services (CMS) from withholding Medicare payments to effectuate the recoupment of the alleged overpayments until an administrative law judge (ALJ) has heard and rendered a decision on the provider's appeal.

In their rulings, a split in authority developed as to a provider's ability to establish a substantial likelihood of success on the merits of its procedural due process claim—that CMS' recoupment of alleged Medicare overpayments without providing the statutorily mandated ALJ hearing within the 90-day prescribed time is a deprivation of the provider's property interest in Medicare payments. The trend began with a Fifth Circuit ruling in *Family Rehabilitation v. Azar,*[1] which reversed an initial district court ruling and found that the district court had jurisdiction to hear Family Rehab's injunction claim. Following the Fifth Circuit jurisdictional decision, the district court granted Family Rehab's preliminary injunction request, ruling that Family Rehab had a property interest in its Medicare payments.

Now, the Eleventh and Fourth Circuits are set to weigh in, with similar cases on appeal. The district court in the Fourth Circuit case ruled in favor of the provider, whereas the district court in the Eleventh Circuit case ruled against the provider. These disparate rulings present the possibility of a circuit split. This article will explore the status of these cases.

The question has also arisen as to whether the same due process relief is available to providers facing financial devastation resulting from CMS's imposition of prepayment review? This article will also explore the potential application of procedural due process rights to providers facing prepayment review.

Medicare Overpayment Appeals

When challenging a Medicare overpayment demand, a provider must complete a four-step administrative appeals process before the provider can access the Article III courts.[2] Following completion of the first two stages of appeal, the third stage—a hearing before and a decision by an ALJ—is statutorily required to occur and a decision to be made within 90 days of the provider's submission of a request for hearing, during which CMS may begin recouping the disputed funds.[3] Despite the statutorily-mandated timeline, a severe backlog has prolonged the wait time for an ALJ hearing from 90 days to three to five years. Although, as the district court in *Family Rehab* stated, most providers can scrape by for 90 days, recoupment during the three to five year extended delay can create financial hardship for many providers.

Status of Procedural Due Process Challenges to CMS' Recoupment of Alleged Overpayments

In the landmark case challenging CMS' recoupment during the prolonged ALJ hearing backlog, the provider in *Family Rehab* asserted a claim for failure to provide procedural due process, and also an *ultra vires* claim, focusing on the statutory directive that ALJs are to conduct and conclude hearings, and render a decision, within 90 days of a request for a hearing.[4]

The Northern District of Texas "reluctantly dismissed the initial temporary restraining order for lack of jurisdiction."[5] On appeal, the Fifth Circuit found that the district court had subject matter jurisdiction to hear Family Rehab's application to obtain injunctive relief. In finding that the district court had jurisdiction to hear the case, the Fifth Circuit applied the "collateral-claim exception," in part, because the provider's claims for injunctive relief were entirely collateral to the substantive relief sought by the provider from the agency.[6]

On remand, the district court held that although the applicable statute authorized CMS to begin recoupment before the ALJ rendered a decision, Congress had not anticipated that ALJ decisions would be delayed much longer than the statutorily prescribed 90 days "and certainly not a delay of three to five years."[7] The court ruled "that forcing Family Rehab to wait three to five years for a hearing while overpayments are in recoupment create[d] a high risk of erroneous deprivation of Family Rehab's property interest."[8]

Following the Fifth Circuit's decision, the Southern District of Texas granted two injunctions to providers in similar circumstances.[9] Likewise, the U.S. District Court for the District of South Carolina recently granted a preliminary injunction and enjoined recoupment of alleged overpayments from a provider's Medicare revenues. The South Carolina case is now on appeal to the Fourth Circuit.[10] Courts finding favorably for providers in evaluating the merits of the procedural due process claims have focused on the extent of irreparable harm faced by the provider and thus, the risk of an erroneous deprivation of a property interest. Indeed, in *Family Rehab*, the provider demonstrated that it had been forced to lay off almost 90% of its staff, and reduced its census from 289 to only eight patients.[11] Another Texas provider demonstrated that it sold an ambulance, reduced its staff to two people, and faced looming bankruptcy,[12] while the South Carolina provider lost over $5 million in revenue and terminated 24 employees.[13]

Contrary to the recent pro-provider rulings, the U.S. District Court for the Middle District of Florida recently found for the government in a similar case. *In Alpha Home Health Solutions LLC v. Secretary of the U.S. Department of Health and Human Services*, the district court denied the provider's motion for a preliminary injunction, finding that a health care provider does not have a constitutionally protected property interest in an overpayment of federal funds.[14] The court further held that the provider could not meet its burden of establishing a substantial likelihood of success on the merits of a due process claim because the provider was not irreparably injured by the recoupment process. Specifically, the court stated that "the fact that thirty patients may face interruption in the continuity of care, while disturbing, is not dispositive. Plaintiff failed to present proof that another qualified home health care provider cannot fill the void created by Plaintiff's down-sizing caused by the recoupment process."[15] Alpha Home Health Solutions is pursuing an appeal to the Eleventh Circuit.

Stemming from the competing appeals in Florida and South Carolina, the Fourth and Eleventh circuits are poised to address the issue, perhaps even more expansively than *Family Rehab*. These cases should be monitored closely by providers and where possible, providers should consider amicus briefing. In light of the similar financial impact, some providers question whether procedural due process claims should extend to providers faced with undergoing prepayment review.

Application to Prepayment Review

Like providers facing recoupment during an extended delay for an ALJ hearing, many providers facing prepayment review encounter the same financial devastation. But whether these providers have a viable procedural due process claim stemming from delayed access to funds is less certain.

The reason for this stems from the statutory language. CMS authorizes RACs to review claims before they are paid to ensure that the provider complied with all Medicare payment rules.[16] Accordingly, the RACs conduct prepayment review on certain types of claims that have historically resulted in high error rates, suggesting improper payments.

Unlike the statutory mandate which dictates the timeline for Medicare overpayment ALJ hearings, there is no direct statutory or regulatory authority upon which the provider can rely to claim

a violation of procedural due process has occurred. Rather, the statutory language governing pre-payment reviews expressly allows CMS to withhold payment upon submission of the claim until the provider has furnished the information necessary to determine whether the claim is payable. In other words, there is nothing in the statutory language that requires CMS to act within a specific time frame during a prepayment review.[17] In the absence of a mandate requiring CMS to act in a certain way, it is unlikely that a provider would be successful in pursuing a procedural due process claim.

Although no court has addressed the issue of prepayment review withholdings directly, if providers continue to experience financial troubles caused by reviews, providers may have no other recourse than to seek judicial intervention. Thus, we suggest carefully monitoring these judicial decisions as courts from around the country continue to wrestle with the issue of procedural due process, and particularly a provider's property interest in Medicare payments for services rendered. There is no question the scope of a provider's procedural due process rights to Medicare payments hangs in the balance.

1 *Family Rehab., Inc. v. Azar*, No. 3:17-CV-3008-K, 2018 WL 3155911, at *1 (N.D. Tex. Jun. 28, 2018).
2 *See* 42 U.S.C. § 1395ff.
3 *Id.* at § 1395ff(d)(3)(A).
4 *Family Rehab., Inc.*, 2018 WL 3155911, at *1.
5 *Id.* at *7.
6 *Family Rehab, Inc. v. Azar*, 886 F.3d 496, 502 (5th Cir. 2018).
7 *Family Rehab, Inc.*, 2018 WL 3155911, at *13.
8 *Id.*
9 *Han Ma Eum, Inc. v. Azar*, No. 4:18-CV-2946 (S.D. Tex. Sept. 26, 2018); *Adams EMS, Inc. v. Azar*, No. CV H-18-1443, 2018 WL 5264244, at *10 (S.D. Tex. Oct. 23, 2018).
10 *Accident, Injury & Rehab., PC v. Azar*, No. 4:18-CV-02173-DCC, 2018 WL 4625791, at *6 (D.S.C. Sept. 27, 2018).
11 *Family Rehab., Inc.*, 2018 WL 3155911, at *16.
12 *Adams EMS, Inc.*, 2018 WL 5264244.
13 *Accident, Injury & Rehab., PC*, 2018 WL 4625791, at *6.
14 *Alpha Home Health Sols., LLC v. Sec'y of United States Dep't of Health & Human Servs.*, 340 F. Supp. 3d 1291 (M.D. Fla. 2018).
15 *Id.* at 1304.
16 CMS, *Medicare Prepayment Review Demonstration*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/RecoveryAuditPrepayment-Review.html.
17 *See* 42 U.S.C. 1385l(e); *see, e.g.*, *Farkas v. Blue Cross & Blue Shield*, 24 F.3d 853 (6th Cir. 1994) ("The use of PPUR [Prepayment Utilization Review] finds statutory support at 42 U.S.C. 1385l(e), which provides that 'no payment shall be made to any provider of services . . . unless there has been furnished such information as may be necessary in order to determine the amounts due such provider . . . .'").