American Hospital Association

RAC Update

September 22, 2016

Federal court denies HHS request for delay in Medicare appeals backlog case

A DC federal court trial judge Sept. 19 denied the government's request to delay further proceedings in a case brought by the AHA and three hospital organizations to compel the Department of Health and Human Services to meet its congressionally mandated deadlines for reviewing Medicare claims denials. "[T]he Court cannot conclude that the Secretary's current proposals will result in meaningful progress to reduce the backlog and comply with the statutory deadlines," Judge Boasberg states. "Although the Court remains loath to intervene in the legislative and executive branches' efforts – or lack thereof, as it may be – to respond to the problem, its 'ultimate obligation is to enforce the law as Congress has written it.' The balance of interests drives the conclusion that there are equitable grounds for mandamus, and the Court will not issue a stay and further delay the proceedings." Melinda Hatton, AHA senior vice president and general counsel, praised the court's decision, saying that it "rightly recognizes that HHS has neither developed nor even offered any realistic plan for resolving the backlog of appeals and that only a court order will ensure that it takes the immediate, concrete, and feasible steps necessary to come into compliance with the mandatory deadlines." The government had requested a delay of the case until Sept. 30, 2017, arguing that such an extended delay was consistent with a February appellate court decision in the lawsuit. In February, the appeals court revived the lawsuit and sent the case back to the lower court, noting that the backlog of delays had gotten "worse, not better." The appellate court also instructed that "in all likelihood," the lower court should order the administration to comply with the appeals deadlines if HHS or Congress failed to make meaningful progress toward solving the problem within a reasonable period of time, pointing to the close of the next appropriations cycle as the deadline for resolution.

QIOs resume two-midnight reviews

Quality Improvement Organizations Sept. 12 resumed claim audits under the two-midnight inpatient admissions policy, the Centers for Medicare & Medicaid Services announced. CMS temporarily paused the patient status reviews in May to improve standardization after AHA shared with the agency hospitals' concerns about the review process. CMS said it was lifting the pause in reviews because the Beneficiary and Family Centered Care QIOs have completed re-training on the two-midnight policy; re-reviewed claims that were previously formally denied; performed

provider outreach on claims affected by the temporary suspension; and initiated provider outreach and education regarding the two-midnight policy. In addition, CMS said it examined and validated the BFCC-QIOs' peer review activities related to short-stay reviews and will continue to review a sample of completed claim reviews each month, monitor provider education calls, and respond to individual provider inquiries and concerns. Questions and comments about the reviews may be submitted to CMS at ODF@cms.hhs.gov.