

A R C L I G H T I N S I G H T S ™

Policy White Paper

RATIONALE DRIFT IN MEDICARE AUDIT APPEALS

A structural analysis of procedural asymmetry in Medicare appeals and its impact on provider fairness and administrative efficiency

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April 2026

AUDIENCE: Congressional Offices | CMS | Industry Stakeholders | Healthcare Policy Organizations

Author note: *This analysis is authored by an entrepreneur with direct operational experience navigating a 17-month UPIC audit and multi-year appeals process for a Medicare-enrolled wound care practice. The author holds a Master of Public Affairs (MPAff) from The University of Texas at Austin LBJ School of Public Affairs and a Master of Business Administration (MBA) from Texas State University. The analysis draws on primary review of original case documents, regulatory text, federal court decisions, HHS/OIG reports, and OMHA statistics.*

Executive Summary

Medicare requires providers to submit all evidence before reconsideration while simultaneously allowing contractors to change the basis for denial after that evidentiary window has effectively closed. This structural mismatch creates predictable procedural harm.

Under 42 CFR § 405.968(b)(5), Qualified Independent Contractors (QICs) may raise new dispositive issues at reconsideration without advance notice. At the same time, evidence front-loading rules under 42 CFR § 405.966(a)(2) and § 405.1018 limit a provider's ability to respond to those newly introduced issues. The result is what this paper terms "rationale drift" — a shift in the legal theory of denial across appeal levels that deprives providers of a meaningful opportunity to respond.

The problem is not that QICs conduct independent review; independent review is valuable and appropriate. The problem is that QICs may introduce entirely new dispositive theories — different in kind, not just degree, from the UPIC's stated rationale — after the provider's evidence window has effectively closed. A provider that invests significant resources building a clinical record to rebut a medical necessity denial has no notice that the QIC intends to decide the case on a categorical "experimental/investigational" theory instead.

Core finding: The structural asymmetry is not a constitutional violation per se, but it creates procedural conditions that raise serious due process questions and, more practically, predictable unfairness that Congress and CMS can fix at minimal cost to program integrity.

This paper documents the regulatory architecture enabling rationale drift, analyzes CMS's built-in defenses and their limitations, presents a concrete case study involving Q4205 (Membrane Graft or Wrap) claims, surveys the administrative law principles that inform the argument, and proposes three targeted statutory and regulatory fixes. Critically, this is the first known analysis to name rationale drift as a discrete, structural problem in Medicare audit administration. No existing legislative proposal, CMS regulation, or advocacy paper addresses it specifically.

Proposed remedies are designed to preserve de novo review authority and robust fraud enforcement while ensuring providers receive fair notice and a meaningful opportunity to respond when QICs shift the dispositive theory of denial.

Why This Matters Now

The Medicare appeals system has just emerged from its historic backlog crisis. Average adjudication time has plummeted from 1,430 days in FY2020 to 69 days in FY2026 Q1, and the pending appeals volume has been largely eliminated. At the same moment, skin-substitute enforcement has reached unprecedented intensity: OIG-documented Part B spending exploded from \$256 million in 2019 to more than \$10 billion in 2024, triggering simultaneous UPIC audits, DOJ prosecutions, the new Fraud Defense Operations Center, the WISeR prior-authorization model, and the CY2026 PFS flat-rate payment reform.

Meanwhile, the March 27, 2025 HHS restructuring has placed OMHA and the DAB under a new Assistant Secretary for Enforcement focused on fraud, waste, and abuse. This convergence creates a narrow policy window: small, targeted procedural fixes can prevent unnecessary ALJ escalations, protect OMHA's recent gains in timeliness, and improve both provider fairness and

program-integrity outcomes before capacity pressures or enforcement momentum generate a new wave of appeals or litigation.

This paper does not argue against strong program integrity enforcement or independent review at successive appeal levels. Rather, it identifies a narrow procedural asymmetry that can be corrected without weakening fraud enforcement — improving both fairness and administrative efficiency within the Medicare appeals system.

I. The Regulatory Architecture That Enables Rationale Drift

A. The Five-Level Appeals Cascade

Medicare fee-for-service claim denials are subject to a five-level administrative appeals process governed by 42 CFR Part 405, Subpart I. The relevant levels for this analysis are:

- Level 1 — MAC Redetermination (42 CFR § 405.940-§ 405.958): The Medicare Administrative Contractor reviews the initial denial. The MAC may consider evidence submitted with the claim and any additional documentation provided by the appellant.
- Level 2 — QIC Reconsideration (42 CFR § 405.960-§ 405.978): A Qualified Independent Contractor conducts an “independent, on-the-record review” of the initial determination and all issues related to payment. This level is the critical juncture where rationale drift occurs.
- Level 3 — ALJ Hearing (42 CFR § 405.1000-§ 405.1140): An Administrative Law Judge at OMHA conducts a de novo hearing. This is the first level at which evidence exclusion rules are fully operative under § 405.1018.

B. The QIC’s Authority to Raise New Issues

The central regulatory provision enabling rationale drift is 42 CFR § 405.968(b)(5), which provides:

“A QIC may raise and develop new issues that are relevant to the claims in a particular case provided that the contractor rendered a redetermination with respect to the claims.”

Two features of this provision are critical. First, the only precondition is that a MAC redetermination occurred — there is no requirement that the new issue bear any relationship to the UPIC’s stated denial rationale, the MAC’s redetermination rationale, or any theory previously raised in the proceeding. Second, there is no obligation to provide advance notice to the provider that a new issue is under consideration, no opportunity for the provider to submit responsive evidence before the QIC rules, and no required explanation of why the issue was not identified or treated as dispositive at the UPIC stage.

This is not, strictly speaking, a de novo standard. Under 42 CFR § 405.968(a)(1), QIC reconsideration is defined as “an independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim.” The term “de novo” in the CFR is reserved for ALJ hearing under § 405.1000(d). Nevertheless, the QIC’s authority

to raise new issues functions as a de facto expansion of the dispute beyond what the UPIC identified, without corresponding procedural protections.

The QIC's authority over policy interpretation is similarly broad. Under § 405.968(b)(1)-(4), QICs are bound by NCDs, CMS Rulings, and DAB precedential decisions, but give only "substantial deference" — not binding effect — to LCDs, CMS program guidance, and manual instructions. A QIC may decline to apply an LCD the UPIC relied upon and substitute its own policy analysis, provided it explains its reasoning. This means the controlling coverage framework can change across levels with no advance notice to the provider.

C. The CMS Program Integrity Manual Framework

The Medicare Program Integrity Manual (MPIM) governs the upstream audit process. Chapter 3 requires that review contractors "include clearly articulated rationale for their findings" and "include a copy of the policy underlying denial in the case file." Chapter 4 governs UPIC operations, requiring that UPICs document their denial basis and provide it to the provider in the findings letter. Despite these procedural requirements at the UPIC level, the MPIM imposes no corresponding constraint requiring QICs to maintain fidelity to the UPIC's articulated rationale or to signal when they are departing from it.

CMS partially addressed this through MLN Matters SE1521 (August 13, 2015; revised May 9, 2016), which instructed MACs and QICs to refrain from developing new denial rationales during post-payment reviews when the original denial reason was cured. SE1521 acknowledged explicitly: "In some cases, where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason." However, SE1521 has three significant limitations: it is sub-regulatory guidance not codified in the CFR; it applies only to post-payment reviews by MACs and QICs, not to UPIC fraud-related denials or prepayment reviews; and it limits the "category" of denial rather than the specific theory within a category, allowing a denial to be upheld on a different medical necessity theory even if the original medical necessity basis was cured.

II. The Evidence Front-Loading Trap

A. The Three-Layer Exclusion Framework

The evidence submission rules create a layered exclusion regime that compounds the harm when QICs introduce new denial theories. Three interlocking provisions operate sequentially:

42 CFR § 405.966(a)(2) establishes the primary front-loading obligation: "Absent good cause, failure to submit all evidence, including documentation requested in the notice of redetermination prior to the issuance of the notice of reconsideration precludes subsequent consideration of that evidence." This means evidence not submitted before the QIC issues its decision is presumptively excluded from all subsequent proceedings.

42 CFR § 405.1018(c)(1)-(2) imposes an additional gate at the ALJ level: evidence not submitted prior to the QIC's reconsideration "must be accompanied by a statement explaining why the evidence was not previously submitted." If no such statement accompanies the

evidence, “the evidence will not be considered.” Critically, these exclusion rules apply to providers, suppliers, and beneficiaries represented by providers — but under § 405.1018(d), they do not apply to CMS or its contractors. The government may introduce new evidence and theories freely; providers face exclusionary bars.

42 CFR § 405.1028 provides the “good cause” exception. Five grounds exist for admitting otherwise-excluded evidence, the most relevant being § 405.1028(a)(2)(i): evidence is material to “an issue addressed in the QIC’s reconsideration and that issue was not identified as a material issue prior to the QIC’s reconsideration.” If no good cause exists, § 405.1028(a)(3) mandates exclusion: the ALJ “must exclude the evidence from the proceeding and may not consider it.

B. Why the Good Cause Exception Is Insufficient

CMS’s implicit defense is that § 405.1028(a)(2)(i) cures any procedural harm from rationale drift. If the QIC raises a new issue, the provider can invoke good cause at the ALJ level to admit responsive evidence. This argument has surface appeal, but fails on closer analysis for four reasons.

First, the good cause exception is discretionary, not automatic. The ALJ “may” admit evidence under good cause — there is no presumption of admission. The provider must affirmatively demonstrate entitlement, and there is no uniform standard for how ALJs evaluate these claims. This introduces an additional layer of uncertainty and variability into a process that already spans multiple years.

Second, the good cause exception does not address the QIC proceeding itself. A provider who learns for the first time in the QIC’s final decision that the dispositive theory has shifted has no recourse within the QIC proceeding. The QIC has already ruled. The good cause exception operates only at Level 3, requiring the provider to escalate to an ALJ hearing — with the attendant cost, delay, and uncertainty — simply to obtain the procedural rights that should have been available at Level 2.

Third, invoking good cause requires the provider to identify and characterize the theory shift accurately, explain why responsive evidence was not available at reconsideration, and submit the evidence in a form the ALJ finds responsive to the new theory. This demands sophisticated legal and clinical expertise that small and mid-size wound care providers often lack without expensive legal counsel.

Fourth, the exception’s existence confirms the problem rather than solving it. CMS built § 405.1028(a)(2)(i) specifically to address the scenario where a QIC raises a new issue — acknowledging that this scenario occurs regularly enough to warrant a remedial mechanism. The existence of a discretionary backstop does not eliminate the need for a structural fix at the point where the harm occurs.

III. Engaging CMS’s Built-In Defenses

Any serious policy argument must squarely address the government's most plausible responses. Several defenses merit direct analysis.

A. “The System Was Designed for Progressive Review”

CMS would argue that the appeals cascade is intentionally structured for progressive review, with each level adding depth and independence. De novo expansion is a feature, not a bug: it ensures that claims are fully evaluated rather than rubber-stamped. Under this view, § 405.968(b)(5) is not a flaw but a safeguard against underdeveloped initial determinations.

This defense is partially correct. Independent review at each level serves genuine program integrity purposes, and this paper does not argue against it. The objection is not to QIC independence — it is to QIC independence exercised without notice. Progressive review is valuable when the provider can track and respond to the evolving case against it. When the theory of denial shifts silently between levels, progressive review becomes progressive prejudice: the provider's earlier investment in building a record is wasted, and the case effectively starts over at the QIC level without procedural reset.

B. “The Evidence Front-Loading Rules Give Providers Ample Opportunity”

A second defense is that the front-loading framework protects providers by requiring the government to develop the record before reconsideration, enabling providers to submit comprehensive evidence early. The good cause exception provides relief in genuine hardship cases.

This defense founders on a foundational asymmetry: providers are required to front-load all evidence, but they are not told what issues they must defend against. The UPIC's denial letter identifies the UPIC's theory — documentation deficiencies, billing inconsistencies, conservative care gaps — and the provider reasonably builds its evidentiary record to rebut that specific theory. If the QIC subsequently decides the case on a categorically different theory, the provider's front-loaded evidence may be substantively nonresponsive. The front-loading rules presuppose a stable dispute; they are not designed for a dispute that changes shape between levels.

C. “Provider-Favorable ALJ Overturn Rates Show the System Works”

A third defense is systemic: providers who are treated unfairly by QICs can and do win at the ALJ level, demonstrating that the multi-level system corrects errors over time. Historically, providers won at the ALJ level at rates of 40-60%, suggesting that QIC decisions are reviewed critically and meaningful relief is available.

This defense has weakened considerably. OMHA data shows the combined provider-favorable rate at the ALJ level has fallen from 31.8% in FY2023 to 22.8% in FY2025, while the unfavorable rate has surged to 61.1%. More fundamentally, requiring providers to escalate to an ALJ hearing to cure a procedural deficiency originating at the QIC level imposes substantial costs — legal fees, management time, cash flow disruption from recoupment, and potential payment suspension — that most small providers cannot sustain. The fact that some providers eventually prevail at Level 3 does not justify procedural harm at Level 2.

D. Rationale Drift as a Driver of Administrative Waste

Rationale drift does not only create fairness concerns — it also drives avoidable administrative cost. When the theory of denial changes at the QIC level without notice, providers are frequently forced to escalate to the ALJ level to respond effectively. This results in:

- Duplication of effort across contractors and adjudicators
- Increased administrative cost for CMS and its contractors
- Extended timelines and cash flow disruption for providers
- Unnecessary utilization of ALJ hearing resources

In effect, the system converts what could be resolved at reconsideration into a Level 3 dispute. In high-volume enforcement categories such as skin substitutes, this dynamic contributes to unnecessary appeals volume and places avoidable strain on OMHA capacity. Addressing rationale drift is therefore not only a fairness reform — it is an efficiency and cost-containment measure.

IV. OMHA Statistics: Context, Not Proof, of Systemic Strain

OMHA publishes detailed decision statistics by fiscal year and quarter. These data are relevant context for evaluating the Medicare appeals environment, though they do not by themselves prove due process failure. The trends are nonetheless noteworthy.

FY	Favorable	Part. Favorable	Unfavorable	Dismissed	Avg. Days
FY2022	27.9%	3.0%	42.6%	26.5%	725
FY2023	29.2%	2.6%	50.2%	18.0%	137
FY2024	27.5%	2.5%	47.6%	22.4%	71
FY2025	21.3%	1.5%	61.1%	16.2%	74
FY2026 Q1	22.8%	1.7%	58.5%	17.1%	69

Source: OMHA Decision Statistics, hhs.gov/about/agencies/omha. Appeals-level data.

Several observations follow. The processing time improvement is significant and real: average adjudication time has fallen from a crisis peak of 1,430 days in FY2020 to 69 days in FY2026 Q1, meeting the statutory 90-day deadline. This represents genuine administrative progress that should not be undermined by structural reforms. The decline in provider-favorable rates — from combined favorable/partially favorable rates above 30% to 22-24% — is noteworthy but admits multiple explanations, including a more aggressive enforcement environment, underlying billing deficiencies in the claims being appealed, and better contractor alignment. The data does not by itself prove structural unfairness.

What the data does support is that escalation to ALJ hearing is not a trivial remedy. With processing times recently compressed and OMHA under staffing pressure from the March 2025 HHS restructuring, the ALJ hearing track may be returning to longer wait times. The Wachler & Associates law firm warned in April 2025 that HHS cuts “could reverse progress and return to multi-year wait times.” In a system where good cause exceptions require ALJ escalation to cure QIC procedural defects, the adequacy of that remedy depends directly on OMHA’s operational capacity.

V. Case Study: The Q4205 Rationale Drift Pattern

A. The Fact Pattern

The following case study is drawn from primary review of original audit and appeal documents and has been anonymized to protect patient privacy. The patient — referred to as Patient A — was a post-surgical abdominal wound dehiscence case receiving mobile wound care services. Patient A was a Medicare Part B beneficiary in her mid-60s with a complex post-operative course involving surgical debridement, IV antibiotics, and NPWT prior to skin substitute application. Clinical documentation showed wound area declining from approximately 97.9 sq

cm at initial grafting to under 20 sq cm over approximately three months of treatment, consistent with a responding wound.

The provider submitted claims for Q4205 (Membrane Graft or Wrap, per square centimeter) paired with CPT codes 15271/15272 (skin substitute graft application, trunk/arm/leg) across six dates of service between July and August 2024. The UPIC (Qlarant, Southwestern Jurisdiction) conducted a post-payment review covering 20 claims across 11 beneficiaries from January through November 2024, denying 16 claims at an 80% error rate.

B. The UPIC's Theory of Denial

The Qlarant Provider Education letter, dated February 28, 2025, articulated a documentation-and-billing theory of denial. For Patient A specifically, Qlarant identified seven grounds for denial:

- Conflicting wound onset date documentation (onset date of 06/13/24 in some records vs. 05/29/24 in others — a semantics dispute between surgery date and initiation-of-care date)
- Failure to document at least four weeks of patient-specific conservative care prior to first skin substitute application
- Absence of a comprehensive wound management plan explaining why the wound failed to respond to standard care
- Insufficient documentation of comorbidity management (albumin 2.7 with no documented interventions; A1c notation repeated without updated values)
- Infection control documentation gap (provider noted “no infection” while earlier records referenced necrotic slough and persistent infection concern post-hospitalization)
- Lack of detailed post-debridement and post-application wound description
- Product amount vs. wound size discrepancy (96 units documented as applied to wound surface of 36.08 sq cm with zero wastage noted)

Qlarant's denial theory is clearly conditional in nature: each ground implies that the service would be payable if adequately documented. The denial is framed as a documentation failure, not a categorical coverage bar. The UPIC cited LCD L35041 (Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds) as the applicable coverage framework, despite the wound being an abdominal dehiscence — a distinction the MAC would later acknowledge.

C. The QIC's Theory of Denial

C2C Innovative Solutions (QIC, Medicare Part B South) issued multiple reconsideration decisions between July and August 2025, all unfavorable. The QIC's dispositive reasoning departed materially from Qlarant's framework in three respects.

First, the QIC acknowledged that the documentation supported the clinical picture. In the decision covering DOS 07/26/2024, the QIC explicitly noted that “the medical records contain a letter as well as a visit note to support the procedure was performed along with the baseline assessment and trialed conservative treatment” and that “the documentation supports

measurements as well as amount of product used and wasted.” In other words, the QIC conceded the documentation deficiencies that Qlarant had identified were addressed — and then denied anyway on a different theory.

Second, the QIC substituted a categorical non-coverage theory: “The QIC finds that Q4205 is experimental and investigational as denoted by the Q code status nomenclature.” The QIC made no reference to the clinical record in reaching this conclusion. The determination was categorical: the product is non-covered, therefore payment is excluded regardless of documentation quality or medical necessity.

Third, the QIC explicitly changed the controlling policy framework: “Although the UPIC cited LCD L35041 for application for bioengineered skin substitutes to lower extremity chronic non-healing wounds and the provider has argued LCD L35041 with the same title, the QIC has determined the correct policy is the Centers for Medicare and Medicaid Services, Internet Only Manual 100-08 — Medicare Program Integrity Manual (MPIM), Chapter 3, Section 3.6.2.2 and Section 1862 of the Act.”

Rationale Shift Comparison: UPIC vs. QIC

Dimension	UPIC (Qlarant)	QIC (C2C Innovative Solutions)
Core theory	Documentation fails Medicare criteria; internal inconsistencies; billing math errors	Q4205 is experimental/investigational by virtue of Q-code status; categorically non-payable
Evidence required	Chart integrity: conservative care timeline, infection resolution, comorbidity management, wastage accounting	Regulatory/coverage arguments: scientific justification that product is not experimental under MPIM § 3.6.2.2
Controlling policy	LCD L35041 (bioengineered skin substitutes, lower extremity)	MPIM Chapter 3, § 3.6.2.2 and SSA § 1862(a)(1)(A)
Conditionality	Implies conditional coverability — service payable if documented correctly	Categorical non-coverage — service not payable regardless of documentation

D. The Legal Defect in the QIC’s Q-Code Theory

Beyond the structural due process problem, the QIC’s Q-code rationale is inconsistent with its own terms. CMS has stated explicitly and repeatedly that HCPCS code assignment does not determine coverage. The CMS HCPCS Level II Coding Procedures page provides verbatim: “HCPCS Level II is a system for identifying items and certain services. It isn’t a methodology or system for making coverage or payment determinations, and the existence of a code doesn’t, of itself, determine coverage or non-coverage for an item or service.” CMS Transmittal R2288CP confirms: “Designation as temporary does not affect the coverage status of the service identified by the code.”

The Medicare Appeals Council reached the same conclusion in BioniCare Medical Technologies, Inc. (July 13, 2009): “Assignment of a HCPCS code does not automatically imply

coverage.” Q codes (temporary codes for items and services that may lack permanent codes) are used for a range of clinical services that are unambiguously covered under Medicare. The inference that Q-code designation alone establishes experimental/investigational status contradicts CMS’s own published guidance and Appeals Council precedent.

There is no National Coverage Determination for skin substitutes or cellular and tissue-based products. In late 2024, all seven MACs proposed final LCDs that would have classified Q4205 among 158 non-covered products — but CMS withdrew all of these LCDs entirely on December 24, 2025, stating that existing coverage policies remain in place during continued review. As of the date of this writing, Q4205 carries a HCPCS coverage indicator of “Carrier Judgment,” not “non-covered.” The QIC’s categorical non-coverage determination is inconsistent with CMS’s own regulatory posture.

VI. Administrative Law Principles: Supporting Arguments

The administrative law framework informs this analysis but is not the primary basis for reform. Courts have historically afforded substantial deference to CMS in Medicare appeals, and constitutional claims in this context are uncertain and resource intensive. The stronger and more actionable argument is structural: the current system creates procedural asymmetry and evidentiary prejudice that can be addressed through targeted regulatory and administrative fixes without requiring judicial intervention.

A. Procedural Due Process: The Mathews Framework

Mathews v. Eldridge, 424 U.S. 319 (1976) establishes the governing three-factor test for procedural due process in benefits adjudication: the private interest affected, the risk of erroneous deprivation, and the government’s interest. Applied to rationale drift, each factor supports reform. The private interest is substantial — UPIC audits routinely involve overpayment demands of hundreds of thousands of dollars, with extrapolation amplifying individual claim denials to enterprise-threatening amounts. The risk of erroneous deprivation is high when providers build a record to rebut one theory and the QIC decides on another. The government’s interest in refusing a brief notice-and-respond period is minimal.

That said, due process claims in Medicare have historically faced deferential review. *Alexander v. Azar*, 613 F. Supp. 3d 559 (D. Conn. 2020), affirmed by the Second Circuit as *Barrows v. Becerra*, 24 F.4th 116 (2022), demonstrates that courts will find constitutional violations when the system denies meaningful review — but the bar is high. The *Mathews* analysis here is strongest as a framework for legislative advocacy, not as a litigation guarantee.

B. The Principle Against Unexplained Theory Shifts

SEC v. Chenery Corp., 318 U.S. 80 (1943), established that agency action must be judged based on the rationale the agency actually relied upon. While *Chenery* applies most directly to judicial review rather than intra-agency reconsideration, the underlying principle remains instructive: parties should be able to understand and respond to the basis for adverse action.

In the Medicare appeals context, the QIC is not reviewing the UPIC's rationale but issuing its own independent decision. However, when the dispositive theory shifts without notice, the provider is deprived of a meaningful opportunity to address that theory at the stage where evidence submission is expected. The concern is not formal doctrinal violation, but practical fairness: the system permits theory shifts without procedural mechanisms to ensure an informed response.

C. Fair Notice

The appeals framework assumes a stable dispute, but the regulatory structure permits the dispute to change shape between levels without notice. *FCC v. Fox Television Stations, Inc.*, 567 U.S. 239 (2012) holds that due process requires “fair notice” of what is required. A provider that receives a UPIC denial specifying documentation deficiencies has not received fair notice that the QIC will deny on a categorical non-coverage theory it has never previously articulated. The provider cannot make an informed decision about whether to invest in reconsideration, what evidence to compile, or whether to seek expert review without knowing the theory it must defeat.

VII. The Enforcement Context and Policy Vacuum

A. The Skin Substitute Enforcement Environment

Understanding rationale drift requires situating it in the current enforcement environment. OIG Report OEI-BL-24-00420 (September 3, 2025) documented that Medicare Part B spending on skin substitutes grew from \$256 million in 2019 to over \$10 billion annually by late 2024 — roughly a 3,800% increase. Skin substitutes now account for more than 15% of all Part B drug spending. The number of billed units rose 83% while average cost per unit increased 153% in a single year.

Multiple enforcement mechanisms are deployed simultaneously: UPIC audits (Qlarant, CoventBridge, and others); Department of Justice prosecutions resulting in a \$1.2 billion fraud plea, a \$90 million indictment, and a \$45 million civil settlement; the new CMS Fraud Defense Operations Center (FDOC), which stopped \$185 million in improper payments in 2025; the WISeR Model (prior authorization demonstration beginning 2026); and the CY2026 PFS Final Rule reducing skin substitute payment rates to a flat \$127.28 per square centimeter.

This enforcement context matters for two reasons. First, it explains why QICs may be reaching for categorical non-coverage theories: in an environment where program integrity contractors view virtually all skin substitute billing as suspect, a categorical bar is administratively simpler than evaluating each claim's medical necessity on its merits. Second, it establishes that rationale drift is not an isolated or accidental phenomenon — it is the predictable product of applying an intensive fraud-reduction enforcement regime through a procedural architecture designed for case-by-case claims review.

B. No Existing Policy Addresses This Problem

The most significant finding in this research is the policy vacuum. No existing legislative proposal, CMS rulemaking, or advocacy organization position paper specifically identifies or proposes remedies for rationale drift between audit levels. This is the first analysis to name the problem as a discrete structural flaw.

The closest existing interventions are the AFIRM Act (S.2368, 114th Congress; S.3078, 116th Congress), sponsored by Senators Hatch and Wyden, which proposed GAO studies on appeals consistency and financial incentives for contractor accuracy, but did not address rationale drift specifically; and CMS SE1521 (2015/2016), which is sub-regulatory, excludes UPIC fraud denials and prepayment reviews, and has not been codified in the CFR. Key advocacy organizations including the Alliance of Wound Care Stakeholders, the American Hospital Association, and the Center for Medicare Advocacy operate in adjacent spaces without targeting inter-level rationale consistency as a named problem.

VIII. Proposed Reforms

The following reforms are designed to preserve independent review authority and robust fraud enforcement while correcting a narrow procedural asymmetry that creates predictable evidentiary prejudice. Each proposal is administratively feasible, low-cost, and capable of implementation through CMS guidance, contractor performance standards, or targeted regulatory amendment.

Reform 1: Issue Map Requirement and Material Issues Notice

Every UPIC audit finding package should include a standardized “Issue Map” separating the denial theory into functional categories (e.g., documentation sufficiency, coding/unit math, medical necessity under applicable policy, product classification/coverage status). This is not a new requirement in substance — UPIC letters already articulate structured denial rationales — but standardization creates a record against which subsequent theory shifts can be measured.

At the QIC level, within 14 days of docketing a reconsideration request, the QIC should issue a “Material Issues Notice” identifying the issues it will adjudicate. If the QIC intends to decide on a rationale not contained in the UPIC Issue Map — for example, elevating a product classification question to dispositive status where the UPIC framed the matter as documentation failure — the QIC must (a) label it a new issue, (b) briefly explain why it was not dispositive at the prior level, and (c) provide the provider a defined response window (suggested: 21 days) to submit evidence and argument on that specific issue.

Implementation path: CMS could implement this through MPIM Chapter 3 and Chapter 4 revisions, QIC contract performance standards, and QIC decision templates — all without Congressional action. Statutory codification under SSA § 1869(c) would provide permanence.

Reform 2: Automatic Good Cause Presumption for New Issues

When the QIC raises a new dispositive issue not present in the UPIC’s denial rationale, any evidence submitted in response to that issue should be deemed timely for all subsequent proceedings — including ALJ hearing under § 405.1028 — without requiring the provider to

separately establish good cause. The automatic presumption should apply only to evidence “material and responsive to the new issue” as identified in the QIC’s Material Issues Notice, preventing the provision from becoming a general evidence-reopening mechanism.

This reform directly addresses the evidence front-loading trap. Under the current regime, a provider who received no notice of a Q4205 coverage theory during the UPIC proceeding is expected to have submitted scientific literature on amniotic membrane biocompatibility before the QIC’s reconsideration decision — evidence it had no reason to compile. The automatic good cause presumption eliminates this structural absurdity without expanding evidence windows for issues that were properly identified at the UPIC stage.

Implementation path: CMS regulation amendment to § 405.1028(a)(2), adding a new subsection providing automatic admissibility for evidence responsive to a new issue first identified in a QIC Material Issues Notice.

Reform 3: Mandatory Issue Disposition Table in QIC Decisions

QIC decisions should include a standardized issue disposition table documenting (a) each issue identified in the UPIC’s denial rationale, (b) whether the QIC sustained, rejected, or declined to reach each UPIC issue, (c) any new issues identified by the QIC and the basis for their introduction, and (d) the dispositive issue(s) on which the decision rests.

This reform serves three functions. First, it creates an explicit record enabling ALJs, providers, and oversight bodies to identify whether rationale drift occurred and how it affected the outcome. Second, it provides accountability for QIC contractors — unexplained departures from the UPIC’s issue map become visible in the decision record. Third, it enables CMS to treat “rationale drift rate” as a measurable contractor performance metric: the percentage of cases where the QIC’s dispositive rationale was not identified as a material issue in the UPIC’s denial letter. Elevated rationale drift rates should trigger performance review, creating contractor accountability without tying compensation to win/loss outcomes in ways that distort incentives.

Implementation path: QIC contract performance standards and decision template requirements under MPIM Chapter 4. Statutory codification would be available through SSA § 1869(c)(3)(B) requiring QIC decisions to “address all issues raised in the initial determination and redetermination.”

IX. Conclusion

Rationale drift is a real, documentable, and structurally enabled problem in the Medicare audit appeals system. It is produced by the interaction of three regulatory features: QIC authority to raise new issues without prior notice (42 CFR § 405.968(b)(5)), evidence front-loading obligations that presuppose a stable dispute (42 CFR § 405.966(a)(2)), and an inadequate discretionary backstop at the ALJ level (42 CFR § 405.1028). The problem is aggravated in high-enforcement categories like skin substitutes, where UPIC contractors deny on medical necessity grounds and QIC contractors pivot to categorical non-coverage theories based on inconsistent Q-code reasoning.

The argument for reform is not primarily constitutional. Due process arguments inform the analysis and provide legislative urgency, but the strongest case is structural and practical: this is a fixable procedural asymmetry that produces predictable harm to providers operating in good faith, imposes unnecessary costs on both providers and the appeals system, and can be remedied without weakening fraud enforcement. The three proposed reforms — Issue Map and Material Issues Notice, Automatic Good Cause Presumption, and Mandatory Issue Disposition Table — are targeted, proportionate, and administratively feasible.

This analysis represents the first effort to name rationale drift as a discrete structural problem in Medicare audit administration and to propose specific procedural remedies. It is offered as a contribution to ongoing policy discourse on Medicare audit reform, and as an invitation to CMS, OMHA, congressional oversight committees, and wound care advocacy organizations to engage with a problem that has gone unnamed for too long.

Call to Action

CMS and congressional oversight bodies have a narrow window to address a correctable structural flaw before enforcement pressure and appeals volume increase further. Lance McNeill recommends immediate pilot implementation of the “Issue Map + Material Issues Notice” framework in high-volume audit categories, including skin substitutes, through revised QIC contract standards and MPIM guidance.

We further recommend that the Senate Finance Committee and House Energy & Commerce Committee request a targeted GAO study on inter-level rationale consistency and its impact on administrative cost and appeals volume.

These reforms do not weaken program integrity. They strengthen it — by ensuring that disputes are resolved earlier, more transparently, and with a complete evidentiary record. Lance McNeill welcomes the opportunity to brief agency leadership, congressional staff, and advocacy organizations and to provide additional case-level documentation supporting these findings.

Key References and Authorities

Statutory

- Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A) (reasonable and necessary standard)
- Social Security Act § 1869(c), 42 U.S.C. § 1395ff(c) (QIC reconsideration authority)
- Social Security Act § 1833e, 42 U.S.C. § 1395l̄e (evidence submission in appeals)

Regulatory

- 42 CFR § 405.966 — Evidence to be submitted with the reconsideration request

- 42 CFR § 405.968 — Conduct of a reconsideration (new issue authority at § 405.968(b)(5))
- 42 CFR § 405.1018 — Submitting evidence at ALJ level (asymmetric exclusion at § 405.1018(d))
- 42 CFR § 405.1028 — Review of evidence submitted by parties (good cause exception)

CMS Manual Guidance

- Medicare Program Integrity Manual (MPIM), Pub. 100-08, Ch. 3 (§ 3.6.2.2: reasonable and necessary in absence of NCD/LCD)
- Medicare Program Integrity Manual, Ch. 4 (UPIC operations and performance standards)
- CMS MLN Matters SE1521 (August 2015, revised May 2016) — limiting rationale expansion in post-payment reviews
- CMS HCPCS Level II Coding Procedures — HCPCS code assignment does not determine coverage
- CMS Transmittal R2288CP — temporary code designation does not affect coverage status

Agency Reports

- OIG Report OEI-03-20-00330 (October 2022) — UPIC program evaluation (gap: no appeal overturn rate data)
- OIG Report A-05-18-00024 (August 2020) — Inconsistent extrapolation review across contractors
- OIG Report OEI-BL-24-00420 (September 2025) — Skin substitute Part B payment trends and fraud concerns
- GAO-16-366 (May 2016) — Medicare appeals process backlog and consistency failures
- OMHA Decision Statistics, FY2022-FY2026 Q1, hhs.gov/about/agencies/omha

Case Law

- *Mathews v. Eldridge*, 424 U.S. 319 (1976) — procedural due process balancing test
- *SEC v. Chenery Corp.*, 318 U.S. 80 (1943) — agency action judged on stated rationale (*Chenery I*)
- *FCC v. Fox Television Stations, Inc.*, 567 U.S. 239 (2012) — fair notice requirement
- *Alexander v. Azar*, 613 F. Supp. 3d 559 (D. Conn. 2020), *aff'd Barrows v. Becerra*, 24 F.4th 116 (2d Cir. 2022) — due process in Medicare appeals
- *BioniCare Medical Technologies, Inc.* (Medicare Appeals Council, July 13, 2009) — HCPCS code assignment does not imply coverage

CMS Coverage Actions

- CMS CY2026 Physician Fee Schedule Final Rule (CMS-1832-F) — skin substitute reclassification and \$127.28 flat rate
- CMS Fact Sheet: Final Local Coverage Determinations (LCDs) for Certain Skin Substitutes Withdrawn (December 24, 2025)

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Medicare Audit Reform Series — Issue 1: Rationale Drift

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