Making the Most of ALJ Hearings for Medicare Appeals

By Amy Fehn

The Centers for Medicare & Medicaid Services (CMS) provide beneficiaries and healthcare providers with a five-step appeals process for disputing Medicare claim denials. The first two steps of the process—redetermination and reconsideration—present a relatively low chance of success when compared to the third level of appeal: the administrative law judge (ALJ) hearing.[1] The Center for Medicare Advocacy, a nonprofit group dedicated to assisting individuals with access to Medicare coverage, recently opined that the first two levels of appeal "operate as time- and effort-wasting hurdles that have to be endured before a beneficiary has any chance of success, which is at the ALJ level."[2]

Unfortunately, in recent years it has become increasingly difficult for providers and beneficiaries to get to the ALJ level of appeal because the Office of Medicare Hearings and Appeals has a backlog so significant that it would take 11 years to process its current workload.[3] Although efforts are underway to alleviate the backlog,[4] the lengthy wait for an ALJ hearing is especially problematic for providers disputing large audits because recoupment of any deemed "overpayments" begins after the reconsideration decision has been issued.[5]

As counsel for beneficiaries or providers who finally make it to the elusive ALJ hearing, it is critical to make the most of this important step of the Medicare appeals process.

Requesting and scheduling the hearing

An ALJ hearing must be requested within 60 days after the appellant receives notice of the reconsideration decision.[6] Hearings are scheduled by the Office of Medicare Hearings and Appeals Division of Centralized Docketing and may be assigned to administrative law judges in any of the field offices—not necessarily the office nearest the appellant.[7] The assigned judge will then issue a notice of hearing and set the date and time of the hearing, which will be conducted by telephone or video teleconference. It is possible to request an in-person hearing, but the request must be in writing and show good cause as to why it is necessary.[8]

An administrative law judge can make a decision on the record if the parties waive the right to a hearing or if the judge finds that the facts are favorable to the appellant.[9]

Prehearing

Any evidence not submitted before the reconsideration decision is issued cannot be considered by the judge unless good cause is shown.[10] Therefore, if an appellant has new evidence to submit at this level, counsel must present arguments in prehearing statements to establish that the appellant had good cause for not submitting the evidence earlier.[11] For example, the regulations state that good cause will be found when the reconsideration decision identifies an issue that was not raised at redetermination and the evidence is material to that issue.[12] In addition, written evidence such as affidavits, prehearing briefs, and expert curriculum vitae must be submitted within 10 days of receiving the notice of hearing.[13]

FOIA requests and discovery

Discovery is only permitted when CMS elects to participate in an ALJ hearing as a party.[14] Because CMS does not need to make its decision regarding party status until the notice of hearing has been issued, using the Freedom of Information Act (FOIA)[15] is often a more effective manner of obtaining information from CMS and its contractors. Information that may be helpful in preparing for the hearing includes written notes and spreadsheets created by reviewers at the lower levels of appeals, credentials of the reviewers, and notes created during interviews of beneficiaries or other parties.

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"Trial Practice" is a regular column of the *Michigan Bar Journal*, edited by Gerard Mantese and Theresamarie Mantese for the Publications and Website Advisory Committee. To contribute an article, contact Mr. Mantese at gmantese@manteselaw.com.

Conduct of the hearing

Parties to the ALJ hearing have the right to appear personally or through a representative to present evidence and state their position.[16] The formality of the hearing varies significantly depending on the assigned judge. Some judges prefer to question the witnesses themselves while others turn the process over to the attorney to interview witnesses and make the case.

Dealing with nonparties

CMS and its contractors may participate in a hearing by filing position papers and providing testimony to clarify factual or policy issues in a case.[17] However, if they have not notified the administrative law judge and the other parties of their intent to be a party, they are not permitted to cross-examine the appellant's witnesses.[18] It is important for counsel to understand the scope of CMS's involvement in the case and be prepared to object to any attempts by a nonparty to cross-examine the appellant's witnesses.

Challenging local coverage determinations

Administrative law judges are bound only by national coverage determinations and not local coverage determinations or CMS program guidance. Judges must, however, give such local coverage determinations and program guidance "substantial deference"; they cannot refuse to follow the policies without giving a reason or explanation for their decision.[19]

One way to challenge the applicability of a local coverage determination is to point out different ways other CMS regions or private payers approach its interpretation in given situations. Effective arguments can also be made for situations that may not have been considered during the determination process. Active policies can be found on the CMS Medicare Coverage Database[20] and retired policies can be found on the Medicare Coverage Database Archive.[21] Public comments on draft local coverage determinations are available on contractor websites such as that of Wisconsin Physician Services, the Medicare administrative contractor for Michigan.[22]

Witness testimony

Frequently, the ALJ hearing involves significant discussion of the medical records at issue. When an overpayment is based on a statistical sample, the judge must base his or her decision on the entire statistical sample.[23] Thus, it is necessary for the judge to consider each date of service even in large audits. Often, physicians will testify on their own behalf and can effectively explain the necessity of the services to the judge. However, when the issues in the audit rely on the correct selection of billing codes, it is often helpful to present a coding expert's testimony to explain the process. Also, for providers such as home health agencies who must rely on the medical judgment of physicians for certification, it is often helpful to have physician testimony to discuss the reasons why the services were medically necessary. For cases involving statistical sampling, the use of a statistical expert is virtually the only way in which the provider can dispute the validity of the statistical methods used by the CMS contractor.

Legal arguments

In addition to defending the merits of the case with witness testimony, counsel for appellants should be prepared to make legal arguments based on applicable statutes and caselaw.

For example, Section 1879 of the Social Security Act applies to certain types of denials, including those for lack of medical necessity, and prohibits denial of payment for services when the provider did not know and could not reasonably have been expected to know that the payment would be denied.[24] Similarly, a provider is considered "without fault" pursuant to Section 1870 of the Social Security Act if the provider exercised reasonable care in billing for and accepting payment, complied with all pertinent regulations, made full disclosure of all material facts, and, on the basis of the information available, had reasonable grounds for assuming that the payment was correct.[25] A provider is also considered to be without fault if a contractor finds an overpayment subsequent to the third year following the year in which the notice of payment was made.[26]

The "treating physician rule" is a legal theory arising out of Social Security disability cases. As articulated by the U.S. Court of Appeals for the Second Circuit, the treating provider's opinion should be "binding on the fact-finder unless contradicted by substantial evidence and [] entitled to some extra weight, even if contradicted by substantial evidence, because the treating source is inherently more familiar with a claimant's medical condition than are other sources."[27] This argument also dovetails nicely with challenges to the reviewers' credentials, as the reviewing panel is required to have "sufficient medical, legal, and other expertise" and, more specifically, a physician must be

included on the panel when reviewing physician services.[28]

Final thoughts

The administrative law judge appeal is not the final step of the Medicare appeals process, but is largely regarded as the most important because of the opportunity for oral arguments and the comparatively high likelihood for success.[29] As counsel for providers and beneficiaries in this process, it is important to take full advantage of the ALJ hearing—by making the best case possible. ■

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ENDNOTES

1. In a recent report, the Government Accountability Office (GAO) found that in FY 2014, the chance of an appellant winning was only 19 percent at the redetermination level, 36 percent at reconsideration, and 54 percent at the ALJ level of appeal. See GAO Report to Congressional Requestors, *Medicare Fee-For-Service Opportunities Remain to Improve Appeals Process*, available at <http://www.gao.gov/products/GAO-16-366>. All websites cited in this article were accessed September 22, 2016.
2. Center for Medicare Advocacy, *Senate Finance Committee Holds Hearing on Medicare Appeals Backlog—Proposed Solutions are of Great Concern* <http://www.medicareadvocacy.org/senate-finance-committee-holds-hearing-on-medicare-appeals-backlog-proposed-solutions-are-of-great-concern>.
3. US Department of Health and Human Services, *HHS Primer: The Medicare Appeals Process* <https://www.hhs.gov/dab/medicare-appeals-backlog.pdf>.
4. 81 Fed Reg 43790 (July 5, 2016).
5. 42 USC 1395ddd(f)(2)(A).
6. 42 CFR 105.1002.
7. See US Department of Health and Human Services, *Request an Administrative Law Judge (ALJ) Hearing* <http://www.hhs.gov/omha/Coverage%20and%20Claims%20Appeals/Request%20an%20ALJ%20Hearing/request_hearing.html>.
8. 42 CFR 405.1020.
9. 42 CFR 405.1000(e) and (g).
10. 42 CFR 405.966(a)(2).
11. 42 CFR 405.1018(c); 42 CFR 405.1028(a).
12. 42 CFR 405.1028(b).
13. 42 CFR 405.1018(a).
14. 42 CFR 405.1037(a)(1).
15. 5 USC 551 *et seq.*
16. 42 CFR 405.1000(b) and (c).
17. 42 CFR 405.1010(c).
18. 42 CFR 405.1008.
19. 42 CFR 405.1062(a). Note that the regulations also state that ALJs are not bound by local medical review policies. However, it is important to note that all local medical review policies have been retired as of 2005. See CMS, *Medicare Coverage Database Archive* <http://localcoverage.cms.gov/mcd_archive/overview.aspx?from2=overview.aspx&>.
20. CMS, *Indexes* <https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx>.
21. CMS, *Medicare Coverage Database Archive* <http://localcoverage.cms.gov/mcd_archive/overview.aspx?from2=overview.aspx&>.
22. See Wisconsin Physician Services, *Draft Policies* <http://www.wpsmedicare.com/j8macpartb/policy/draft>.
23. 42 CFR 405.1064.
24. 42 USC 1395pp.
25. 42 USC 1395gg; CMS, *Medicare Financial Management Manual* (Publication #100-06), ch 3, § 90 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c03.pdf>.
26. *Medicare Financial Management Manual*, § 80.
27. *Schisler v Bowen*, 851 F2d 43, 47 (CA 2, 1988). Although HCFA Ruling 93-1 concluded that the treating physician rule should not be applicable to inpatient hospital or SNF services, the ruling did not address Part B claims.
28. 42 CFR 405.968(c)(1).
29. Pursuant to 42 CFR 405.1124, the Medicare Appeals Council is not required to allow oral arguments, and appealing a matter to federal court is cost prohibitive for many appellants.