PEEKING BEHIND THE ROBES: A NOT-SO-FLATTERING LOOK AT MEDICARE'S ADMINISTRATIVE LAW JUDGES

Michael Barry*

* Michael P. Barry. B.A., Brigham Young University, J.D., University of Missouri-Columbia School of Law. My experience includes service as Legal Counsel, Chief Compliance Officer, and HIPAA Privacy Officer. I have argued dozens of Medicare appeals before Administrative Law Judges. All opinions expressed in this article are mine.

http://dx.doi.org/10.18060/18960

I. INTRODUCTION

Over forty-nine million elderly and disabled Americans currently receive health care coverage through Medicare. It is a massive government program that accounted for 14% of the federal budget in 2013.[1] In the event that Medicare refuses to cover an enrollee's request for a specific medical treatment, item, or prescription drug, that individual may appeal the decision through a multi-tiered appeals process. The third stage of a Medicare appeal involves a hearing before an administrative law judge (ALJ). These ALJs are employed by the Office of Medicare Hearings and Appeals (OMHA), an agency within the U.S. Department of Health and Human Services (HHS). ALJs have a critical responsibility to take evidence at hearings, serve as a trier of facts, and, ultimately, render a decision on the merits of the appeal.

In November 2012, the Office of Inspector General (OIG) of HHS issued a report entitled *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*.[2] The OIG Report provides an interesting statistical analysis of ALJ cases, along with ten recommendations from the OIG intended to improve the accuracy, efficiency, and reliability of ALJ decisions. But more importantly, it reveals serious deficiencies by ALJs, and their staff, that need to be addressed and remediated above and beyond the OIG recommendations.

Part II of this article will provide a brief overview of Medicare and its appeals process, with an emphasis on the third level of appeals before ALJs. Part III will examine the findings and recommendations from the OIG. And Part IV will provide an in-depth analysis of the major deficiencies and failures of Medicare's ALJs.

---

[1] Kaiser Family Foundation, *The Facts on Medicare Spending and Financing* (July 28, 2014), *available at* http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/, *archived at* http://perma.cc/9FEV-5RX5.

[2] OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., OEI-02-10-00340, IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS (2012) [hereinafter OIG REPORT].

II. MEDICARE AND ITS APPEALS PROCESS

Medicare is a "federally funded medical insurance program for the elderly and disabled."[3] It originally became law in 1965, when it passed as an amendment to the Social Security Act.[4] Medicare is available to individuals age sixty-five or older and disabled persons entitled to Social Security disability benefits. Individuals younger than sixty-five who have end-stage renal disease or amyotrophic lateral sclerosis (ALS)[5] are also entitled to participate. The Medicare program is administered jointly through HHS and the Centers for Medicare & Medicaid Services (CMS).[6]

Today Medicare is comprised of four Parts: A, B, C, and D. Part A is known as the Hospital Insurance (HI) program. It covers inpatient hospital care, post-acute home health care services, short-term care in skilled nursing facilities, and hospice care.[7] Part B, the Supplementary Medical Insurance (SMI) program, helps pay for outpatient medical care from physicians and other medical practitioners, laboratory services, some home health care, physical and occupational therapy, and durable medical equipment (DME) and supplies.[8] Part C, also known as Medicare Advantage (MA),[9] allows private health insurance plans to contract with the federal government to provide Medicare-covered health services under Parts A and B, with

---

[3] Fischer v. U.S., 529 U.S. 667, 671 (2000).

[4] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified at 42 U.S.C. § 1395 *et seq.* (2014)).

[5] ALS is also known as Lou Gehrig's disease.

[6] Prior to restructuring in 2001, CMS was known as the Health Care Financing Administration (HCFA).

[7] *See* 42 U.S.C. §§ 1395c-d (2014).

[8] *See* 42 U.S.C. §§ 1395j-k (2014).

[9] The Part C program was originally known as "Medicare+Choice," but the name was changed to "Medicare Advantage" in December 2003 with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (Dec. 8, 2003) [hereinafter MMA].

some exceptions. [10] And Part D provides coverage for prescription drugs, biologicals, and vaccines. [11] Part D is offered through prescription drug plans (PDPs) and MA plans with drug coverage.

Medicare's appeal process is designed to reverse erroneous claim denials and correct mistakes.[12] It can only begin after an "initial determination" is made that denies coverage, in whole or in part, for a Medicare enrollee.[13] The enrollee, an appointed representative, or assignee (i.e., the practitioner or medical supplier who provided the service or item) can then appeal this decision. The appeals process includes five levels, and the appellant must exhaust each level before proceeding to the next level. The five levels are:

> **Level 1**: For Parts A and B, a Medicare contractor will make a "redetermination."[14] Here the same Medicare contractor who made the initial determination will take a second look at the claim, although a different individual will review it. For Parts C and D, the MA plan or the PDP will also review and take a second look at the claim.[15] There is no minimum amount in controversy for a Level 1 appeal.

---

[10] *See* 42 U.S.C. §§ 1395w-21 *et seq.* (2014). The Balanced Budget Act created Part C in 1997 to encourage wider availability of managed care options in Medicare through health maintenance organizations (HMOs) and the participation of other types of coordinated care plans. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251 (1997).

[11] *See* 42 U.S.C. §§ 1395w-101 to -151 (2014). Medicare's Part D program was established pursuant to the MMA. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §§ 101-11, 117 Stat. 2066, 2174-76 (2003).

[12] *See* 42 U.S.C. § 1395ff (2014); 42 C.F.R. §§ 405.900 -.1140 (2014).

[13] 42 C.F.R. § 405.803(a) (2014); *see also* 42 C.F.R. § 405.920 (2014).

[14] *See* 42 C.F.R. §§ 405.940-.958 (2014).

[15] *See* 42 C.F.R. §§ 422.578-.590 (2014); 42 C.F.R. §§ 423.580-.590 (2014).

Level 2: For Parts A and B, a "reconsideration"[16] will be conducted by a "Qualified Independent Contractor" (QIC), a third-party reviewer that is under contract with CMS.[17] For Parts C and D, a review will be conducted by an "Independent Review Entity" (IRE), also a third-party reviewer contracted by CMS.[18] Level 2 appeals are conducted after a review of evidence in the case file.[19] There is no minimum amount in controversy for a Level 2 appeal.

Level 3: Review before an ALJ from the HHS OMHA. The minimum amount in

---

[16] *See* 42 C.F.R. § 405.974 (2014).

[17] QICs are assigned based on the geographic location where the service was rendered. CMS has designated QICs for the following jurisdictions: Part A East Jurisdiction – Maximus, Inc. (Maximus); Part A West Jurisdiction – Maximus; Part B North Jurisdiction – C2C Solutions, Inc. (C2C); Part B South Jurisdiction – C2C; and DME Jurisdiction – C2C. In 2013 alone, QICs processed approximately 1,392,000 reconsiderations. *See* CMS Fact Sheet, Original Medicare (Fee-For-Service) Appeals Data – 2013, available at http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html (accessed by downloading Appeals Fact Sheets).

[18] *See* 42 C.F.R. §§ 422.592-.596 (2014); 42 C.F.R. §§ 423.600-.604 (2014). CMS has designated Maximus as the IRE for Part C and Part D appeals. In 2013, Maximus processed 142,953 reconsiderations. *See* CMS Fact Sheet, *Part C Reconsideration Appeals Data – 2013*, available at http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/IRE.html (accessed by downloading Fact Sheets: Part C Reconsiderations Appeals Data). *See also CMS Fact Sheet, Part D Reconsideration Appeals Data – 2013*, available at http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Reconsiderations.html (accessed by downloading Fact Sheets Part D Reconsideration Appeals Data).

[19] The case file refers to the administrative record, which generally includes claims, medical records, and other evidence. *See* 42 C.F.R. § 405.1044(b) (2014).

controversy for a claim at the ALJ level is $150.[20]

Level 4: Review by the Medicare Appeals Council (MAC) from the HHS Departmental Appeals Board.[21] There is no minimum amount in controversy for an appeal at this level, but the MAC may decline to review a case. This is the final administrative review level for Medicare appeals.

Level 5: Review by a local federal district court. The minimum amount in controversy is $1,460.[22]

A. Level 3 (ALJ) Appeals–Additional Details

Because this article deals primarily with Medicare appeals at the ALJ level, additional details about this appellate level will be discussed. Any party dissatisfied with the outcome of a Level 2 appeal has the right to request a hearing before an ALJ.[23] ALJ hearings may be conducted in three ways: (1) in-person, (2) by video-teleconference, or (3) by telephone.[24] Because OMHA's ALJs operate out of just four regional offices,[25] in-person

---

[20] *See* Medicare Appeals: Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2014, 78 Fed. Reg. 59702-01, 59703 (Sept. 27, 2013). *See also* 42 C.F.R. § 405.1006(b) (2014). In 2014, the minimum amount in controversy was $140.

[21] The MAC is located in Washington, D.C.

[22] *See* Medicare Appeals: Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2014, 78 Fed. Reg. 59702-01, 59703 (Sept. 27, 2013). *See also* 42 C.F.R. § 405.1006(b) (2011). In 2014, the minimum amount in controversy was $1,430.

[23] *See* 42 C.F.R. §§ 405.1002, 422.600, 423.1970 (2014).

[24] *See* 42 C.F.R. §§ 405.1000(b) (2007), 405.1020(b) (2011); Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2013, 77 Fed. Reg. 59618-01 (Sept. 28, 2012).

[25] The names and locations of OMHA's regional offices are: (1) Mid-Atlantic Field Office in Arlington, Virginia; (2) Southern Field Office in Miami, Florida; (3) Mid-West Field Office in Cleveland, Ohio; and (4) Western Field Office in Irvine, California. OMHA's central office is

hearings are not very common and are provided only in "special or extraordinary circumstances."[26] OMHA currently has 65 ALJs on staff. A denied claim at Level 2 can only be appealed to Level 3 if it meets the $150 minimum amount in controversy. However, if a single denied claim fails to meet the $150 threshold, an appellant may aggregate claims that involve "common issues of law and fact" in order to reach the required dollar minimum.[27]

An ALJ's review of an appeal is *de novo*.[28] An ALJ is subject to several types of mandatory and persuasive authority. "All laws and regulations pertaining to the Medicare and Medicaid programs, including . . . Titles XI, XVIII, and XIX of the Social Security Act and applicable implementing regulations, are binding on ALJs."[29] National coverage determinations (NCDs) are also "binding,"[30] so an ALJ "may not disregard, set aside, or otherwise review an

---

located in Arlington, VA. The locations of the regional offices may appear to be quite random. However, HHS selected these locations based on research that considered, among other things, the then-current and projected geographic distribution of Medicare claims appeals. *See* Changes to the Medicare Claims Appeal Procedures, 74 Fed. Reg. 65296, 65322 (December 9, 2009).

[26] 42 C.F.R. § 405.1020 (b) (2) (2014).

[27] 42 C.F.R. § 405.1006 (e) (2014). For appellants, "common issues of law and fact" means that "the claims sought to be aggregated are denied, or payment is reduced, for similar reasons and arise from a similar fact pattern material to the reason the clams are denied or payment is reduced." 42 C.F.R. § 405.1006 (a) (1) (2014).

[28] *See* 42 C.F.R. § 405.1000 (d) (2014). In a *de novo* hearing, the reviewing body considers the "matter anew, giving no deference to a lower court's findings." BLACK'S LAW DICTIONARY 738 (8th ed. 2004). CMS states that in a *de novo* hearing, "[a]djudicators at each level of appeal make a new, independent and thorough evaluation of the claim(s) at issue, and are not bound by the findings and decision made by an adjudicator in a prior determination or decision." CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL, Pub. L. No. 100-04, ch. 29, § 110 (2013) [hereinafter MCPM], *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html.

[29] 42 C.F.R. § 405.1063(a) (2014).

[30] 42 C.F.R. §§ 405.1060(a)(4) (2014).

NCD."[31] But an ALJ may review the facts of a particular case to determine whether the NCD has been "applied correctly" to the claim.[32] On the other hand, an ALJ is not bound by local coverage determinations (LCDs)[33] and CMS guidance.[34] An ALJ, however, must "give substantial deference to these policies if they are applicable to a particular case."[35]

CMS or one of its contractors may elect to participate in an ALJ hearing as either a participant or a party.[36] As a participant, CMS can file position papers or "provid[e] testimony to clarify factual or policy issues in a case," but it may not call or cross-examine witnesses.[37] An ALJ has the option to request that CMS, and/or its contractors, participate in a hearing, but the ALJ does not have authority to mandate CMS' participation.[38] If CMS elects to participate as a party, it may "file position papers, provide testimony to clarify factual or policy issues, [and] call witnesses or cross-examine the witnesses of other parties."[39]

All evidence considered by the ALJ must have been submitted previously to the QIC or IRE during the Level 2 appeal. With the exception of verbal testimony offered

---

[31] 42 C.F.R. § 405.1060(b)(1) (2014). An NCD is "a determination by the [HHS] Secretary with respect to whether or not a particular item or service is covered nationally . . . but does not include a determination of what code, if any, is assigned to a particular item or service covered . . . or a determination with respect to the amount of payment made for a particular item or service so covered." 42 U.S.C. § 1395ff(f)(1)(B) (2014). *See also* 42 C.F.R. § 405.732(a) (2011).

[32] 42 C.F.R. §§ 405.732(b)(2), 405.860(b)(2) (2011).

[33] An LCD is a decision by a contractor or carrier under Medicare Part A or Part B whether to cover a particular service on a contractor-wide basis in accordance with Medicare's "reasonable and necessary" criteria for certain diagnoses/diagnosis codes. 42 C.F.R. § 400.202 (2014). *See also Information About LCDs and LCD Challenges,* CMS.GOV, http://www.cms.gov/medicare-coverage-database/. ("Medicare contractors develop LCDs when there is no NCD, or when there is a need to further define an NCD.")

[34] *See* 42 C.F.R. § 405.1062(a) (2014).

[35] *Id.*

[36] *See* 42 C.F.R. §§ 405.1010(b), 405.1012(a) (2014).

[37] 42 C.F.R. § 405.1010(c) (2014).

[38] 42 C.F.R. § 405.1010(a) (2014).

[39] 42 C.F.R. § 405.1012(c) (2014).

during the hearing, [40] any "new evidence" that was not submitted during Level 2 "must be accompanied by a statement explaining why the evidence was not previously submitted."[41] The ALJ will then consider whether "good cause" exists for submitting the evidence for the first time at the ALJ level.[42] If the ALJ does not find "good cause," then the evidence must be excluded from the hearing and the ALJ may not consider it when making his or her determination.[43] If "good cause" exists, then the ALJ may consider the evidence.[44]

During a hearing the ALJ may question the parties and other witnesses.[45] The parties are also allowed to question witnesses.[46] Any party to the hearing has the right to "present evidence and to state his or her position."[47] Parties may also present written statements to the ALJ about the facts and the law material to the case.[48] These documents must be provided to the other parties at the same time they are filed with the ALJ.[49] Following the hearing, the ALJ must issue a decision in 90 days. Otherwise, the appellant can escalate the appeal to the MAC.[50]

---

[40] 42 C.F.R. § 405.1018(d) (2014).

[41] 42 C.F.R. § 405.1018(c) (2014).

[42] 42 C.F.R. § 405.1028(a) (2014). The applicable Medicare regulations inconveniently do not include a definition of "good cause." However, CMS fills in the gaps with its own conditions and examples of good cause for enrollee, providers, and suppliers. See MCPM, *supra* note 29, at §§ 240.2-.4.

[43] 42 C.F.R. § 405.1030(e) (2014). *See also* 42 C.F.R. § 405.1028(c) (2014).

[44] 42 C.F.R. § 405.1030(d) (2014).

[45] *See* 42 C.F.R. § 405.1030(b) (2014).

[46] *See* 42 C.F.R. § 405.1036(g) (2014).

[47] 42 C.F.R. § 405.1036(a)(1) (2014).

[48] *See* 42 C.F.R. § 405.1036(c) (2014).

[49] *Id.*

[50] *See* 42 C.F.R. §§ 405.1034; 405.1052; 405.1104 (2014).

III. OIG REPORT

A. Methodology

The OIG Report is largely based on a statistical analysis of ALJ appeals that were decided in fiscal year 2010. It is also the result of findings from OIG interviews with ALJs and their support staff. The OIG also interviewed the Chief ALJ, the Executive Director of OMHA, the Managing ALJ from each OMHA field office, [51] and a sample of ALJ teams. Interviews were also conducted with key staff from four of the five QICs and the Administrative QIC, which provides support to QICs. Finally, the OIG reviewed relevant Medicare policies, procedures, OMHA and CMS training materials, and other data.

It is relevant to note that the scope of the OIG's review was less than comprehensive. The OIG failed to interview any administrators of prescription drug plans (PDPs) and Medicare Advantage (MA) plans. It also neglected to interview anyone from Maximus, the IRE that is heavily involved in Level 2 Part C and Part D appeals. Furthermore, the OIG did not consult any providers who are regularly involved in the appeals process. [52] The OIG also failed to interview any State Medicaid agencies that may appeal when questions arise as to whom should pay "for services or items received by individuals covered by both Medicare and Medicaid.[53] As a result, the OIG has delivered a report that includes a good analysis of Medicare's ALJs, but is nonetheless incomplete.

---

[51] "The Managing Administrative Law Judge (MALJ) is responsible for the administration of the field office, and is charged with ensuring the just, timely, accurate, and professional adjudication of all Medicare claims appeals." 74 Fed. Reg. 65,296, 65,323 (December 9, 2009).

[52] Here "provider" refers generally to those who provide medical treatment or medical supplies to Medicare enrollees. It therefore includes physicians, clinics, hospitals, provider groups, skilled nursing facilities (SNFs), and medical suppliers, such as those who provide durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

[53] Individuals with coverage under both Medicare and Medicaid are known as "dual eligibles."

B. Findings

1. Providers Filed 85% of ALJ Appeals

For its report, the OIG analyzed a total of 40,682 appeals that ALJs adjudicated in fiscal year 2010.[54] One would naturally expect that the majority of appeals would be filed by Medicare members themselves. Yet the OIG found that 85% of all appeals were filed by providers.[55] This is likely explained by the significant financial interest providers have in the outcome of appeals, particularly for Medicare patients in need of treatment in acute and post-acute settings. The average provider filed six appeals.[56] Only 11% of the appeals were filed by actual Medicare members.[57]

Some providers filed appeals so frequently that the OIG created a special category to identify them. The OIG designated providers who filed at least fifty appeals in a fiscal year as "frequent filers."[58] Incredibly, ninety-six providers fell into this category,[59] and one provider managed to file 1046 appeals in 2010 alone.[60] Furthermore, frequent filers actually filed an even greater number of appeals since at least some of their appeals were approved at Levels 1 or 2 and never reached an ALJ.

The high percentage of appeals filed by providers points to a significant problem with the Medicare appeals process. Providers with claims lacking true merit have little inducement to accept Level 2 denials by QICs or IREs. ALJ staff indicated that providers are incented to appeal "every payment denial" since the actual cost of an appeal is minimal, and there is a statistical likelihood of a favorable

---

[54] OIG REPORT, *supra* note 2, at 8.

[55] *Id.*

[56] *Id.* To round out the total, 3% of the appeals were filed by State Medicaid agencies, and around 1% were classified by the OIG as "unknown." *Id.*

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.*

decision.[61] Due to the sheer number of frequent filers, the decision to appeal every treatment denial is likely built into the business model as well as the policies and procedures of many providers. This fact is troubling since appellants with meritless claims or those that lack medical necessity are motivated to appeal denials and game the system until a favorable decision is reached. In essence, the more often these providers dip their buckets into the well of Medicare appeals, the greater the likelihood they will come up with Medicare dollars.

In order to curb this abuse of the appeals process by frequent filers and other providers, the OIG recommended that OMHA seek statutory authority to implement a "modest filing fee" for appellants.[62] To make the fee fair and effective, the OIG suggested that OMHA create a scaled fee that is based on the dollar amount at issue in the appeal.[63] The OIG also noted that the filing fee should not apply to beneficiaries because providers have greater financial resources than the average Medicare enrollee. These are excellent proposals by the OIG that should, if implemented, counteract the abuse of the appeals process by some providers.

2. CMS Participation in Appeals

The OIG found that CMS participated in 10% of Level 3 appeals in 2010.[64] CMS has the option to participate in ALJ appeals, and may do so as either a participant or a party. However, CMS rarely chose to participate as a party, which would allow it to submit evidence, call or cross-examine witnesses, and appeal to the MAC.[65] When CMS chose to participate, it provided testimony in 61% of appeals and submitted position papers to the ALJs in the remaining

---

[61] *Id.* at 9.
[62] *Id.* at 19.
[63] *Id.*
[64] *Id.* at 13.
[65] *See* 42 C.F.R. § 405.1012(c) (2014).

39%.[66] Appellants were 16% less likely to prevail when CMS was involved in an appeal.[67]

ALJ staff cited several benefits from CMS participation in appeals. The primary benefit appears to be an improved relationship between both agencies. ALJ staff also indicated that CMS often provided them with "needed information"[68] and helped them understand the importance of including specific detail in decisions and position papers to ALJs.[69] CMS intends to join more appeals as a party, rather than as a participant, to allow CMS to better present its position on certain issues being appealed.[70]

Due to the apparent benefits of collaboration, the OIG recommended that CMS expand its participation in ALJ appeals.[71] The OIG also instructed CMS to strategically decide which types of appeals most warrant CMS participation, such as Part A hospital appeals or appeals from frequent filers.[72] Finally, CMS was urged to create formal participation guidelines, including the specific scenarios to determine whether to participate in an appeal as a party or as a participant.[73]

The author concurs with these OIG recommendations. More frequent involvement in appeals by CMS will improve the reliability and accuracy of ALJ decisions. And as I will discuss in section IV.A., *infra*, it will assist ALJs who frequently have difficulty interpreting and applying complex Medicare guidelines and regulations.

3. Accepting New Evidence

Medicare regulations are clear that ALJs may only consider new evidence that was not proffered during Level 2

---

[66] OIG REPORT, *supra* note 2, at 13.

[67] *Id.*

[68] The OIG REPORT failed to include any examples of the "needed information" that CMS provided.

[69] OIG REPORT, *supra* note 2, at 14.

[70] *Id.*

[71] *Id.* at 19.

[72] *Id.*

[73] *Id.* at 20.

if "good cause" exists for submitting the evidence.[74] Absent good cause, the evidence must be excluded and the ALJ cannot consider it.[75] Despite these unambiguous standards, the OIG found that ALJs typically accepted new evidence whenever it was submitted. The author has also found many ALJs to be suspect in their application of the good cause standard. Often, over repeated objections, ALJs admit new evidence by claiming that the objecting party was not "harmed" by the evidence.

To address this issue, the OIG charged OMHA and CMS to revise the regulations to "include additional examples as well as factors for ALJs to consider when determining good cause."[76] Following the OIG Report, CMS revised its claims processing manual in June 2013 to include conditions and examples of good cause for enrollees, providers, and suppliers.[77] Although this guidance is not in the binding form of regulations, it provides much needed direction to ALJs and parties to an appeal.

4. Additional OIG Recommendations

The OIG issued additional recommendations at the conclusion of its report. First, the OIG urged OMHA and CMS to work together to provide "coordinated training" on an annual basis to ALJs and QICs on Medicare policies.[78] Through this measure, the OIG hopes to increase the consistency between Level 2 and Level 3 appeals.[79] One area of focus that the OIG identified was Part A hospital appeals where ALJs reversed QICs in nearly three-quarters of appeals.[80]

Second, OMHA and CMS should seek statutory authority to postpone appeals from appellants who are concurrently being investigated for fraud.[81] The decision to

---

[74] 42 C.F.R. § 405.1028(a) (2014).
[75] *See* 42 C.F.R. §§ 405.1028(c), 405.1030(e) (2014).
[76] OIG REPORT, *supra* note 2, at 18.
[77] *See* MCPM, supra note 29, at §§ 240.2-.4.
[78] OIG REPORT, *supra* note 2, at 17.
[79] *Id.*
[80] *Id.*
[81] *Id.* at 18.

postpone appeals should only be made by OMHA and CMS staff that are not directly responsible for deciding appeals. And third, OMHA should determine if "specialization" by ALJs would improve the efficiency of Level 3 appeals.[82] But specialization, the OIG noted, may complicate the statutory requirement to have appeals assigned randomly among ALJs.[83]

IV. MAJOR DEFICIENCIES WITH ADMINISTRATIVE LAW JUDGES

In the course of conducting this study, the OIG was able to unearth several issues with Medicare ALJs and Level 3 appeals that need to be corrected. These problems, as discussed in section III, have relatively easy solutions. They also do not indicate any systemic issues with ALJs or OMHA. But the OIG did manage to identify other ALJ deficiencies that can be classified as "major" problem areas. The OIG failed, however, to explore these deficiencies in depth. Section IV will address these issues.

A. Knowledge, Expertise, and Competency of ALJs

The OIG found that ALJs reversed Level 2 decisions by Quality Independent Contractors (QICs), and decided fully in favor of appellants, in 56% of appeals.[84] And an additional 6% of ALJ decisions were partially favorable to appellants.[85] This overturn rate of a lower adjudicatory body is extremely high. In an analysis of data from civil cases in federal court from 1988-97, for example, only 18% of cases were reversed on appeal.[86] A similar analysis of appeals from civil cases in State courts found a reversal rate of just 32.1%.[87] The 56% reversal rate by ALJs therefore

---

[82] *Id.* at 19.

[83] *Id.*

[84] *Id.* at 9.

[85] *Id.*

[86] *See* Theodore Eisenberg & Michael Heise, *Plaintiphobia in State Courts? An Empirical Study of State Court Trials on Appeal*, 38 J. Legal Stud. 121, 129-30 (2009).

[87] *Id.* at 130.

raises numerous questions. The OIG found several reasons for this high overturn rate, and they reflect directly on the knowledge, expertise, and competency of the ALJs hired, trained, and retained by OMHA.

1. Decisions Based on "Intent" Rather Than Applicable Law

Both QIC and ALJ staff indicated to the OIG that ALJs tended to interpret Medicare policies "less strictly" than QICs.[88] ALJ staff also acknowledged that ALJs often decided in favor of appellants when the "intent," but not the letter, of Medicare policy was met.[89] QICs, on the other hand, based their decisions on strict interpretations of Medicare guidance. For instance, the OIG found cases where QICs denied payment because enrollees met only 9 out of 10 criteria in a local coverage determination (LCD).[90] Clearly CMS' criteria were not met. Yet on appeal ALJs reversed the QICs and approved coverage since the ALJs felt that the appellants "met the broader intent of the policy."[91] One must wonder how these ALJs divined the "broader intent" of Medicare policy when CMS' standard is to only cover treatments that meet the established criteria.

In another example, Medicare covers home health services under Part A when several specific requirements are met. One criterion is that the member must be "homebound" (i.e., confined to his or her home).[92] The OIG identified appeals where QICs denied home health services for enrollees because they failed to meet the homebound requirement.[93] Yet ALJs reversed the QIC determinations

---

[88] OIG REPORT, *supra* note 2, at 10-11.

[89] *Id.* at 11.

[90] *Id.*

[91] *Id.*

[92] To qualify for home health services, a member must (1) be homebound; (2) need intermittent skilled nursing care, physical or speech therapy, or continuing occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician. *See* 42 U.S.C. § 1395f(a)(2)(C) (2014); 42 C.F.R. § 409.42 (2013).

[93] OIG REPORT, *supra* note 2, at 11.

in some appeals because they considered the services to be reasonable and necessary, while completely ignoring the homebound requirement

The loose interpretation of Medicare laws, regulations and CMS guidance by ALJs seriously undermines the financial integrity of the Medicare program. And the laissez-faire approach toward Medicare law calls into question the role of many ALJs as a decision-maker in appeals. ALJs are not delegated discretionary authority to override Medicare laws and regulations and base their decisions on their own amorphous standards. Nor can ALJs unilaterally decide to cover treatments, supplies, or prescription drugs when there is controlling Medicare authority that dictates otherwise. In fact, "[a]ll laws and regulations pertaining to the Medicare and Medicaid programs . . . *are binding* on ALJs."[94] Any ALJ who issues a decision that disregards this binding authority has placed his or her own criteria for coverage above lawmakers, CMS regulators, and medical experts who developed the parameters for coverage.

Most ALJs understand this and adjudicate appeals accordingly. Nonetheless some ALJs have utilized a clever way to sidestep Medicare's mandatory authority when they disagree with it. They accomplish this by manipulating the fact that although Medicare laws and regulations are binding, CMS manuals are not. Instead, ALJs must afford "substantial deference" to the manuals when they are applicable.[95] When drafting a decision that contravenes binding Medicare authority, these ALJs will conveniently only cite the applicable CMS manual. Any skilled ALJ can easily explain why the particular facts of an appealed case are unique and fall outside of the manual's criteria. With such judicial machinations, the treatment can be covered pursuant to the ALJ's own coverage standards.

---

[94] *See* 42 C.F.R. § 405.1063(a) (2014) (emphasis added). *See also* 74 Fed. Reg. 65296, 65327 (December 9, 2009) ("ALJs . . . are bound by the Medicare statute, CMS regulations, CMS rulings, and NCDs.")

[95] 42 C.F.R. § 405.1062(a); 74 Fed. Reg. 65,296, 65,311 (December 9, 2009).

The author is aware of such a scenario from a Level 3 appeal involving Part C. The appeal pertained to an enrollee's stay in a skilled nursing facility (SNF), and both the Medicare Advantage (MA) plan and Maximus—the independent review entity (IRE)—had previously denied the enrollee's appeal because the stay failed to meet Medicare's four criteria for SNF coverage. These criteria are stated in Medicare regulations and are therefore binding on ALJs.[96] But the criteria are also repeated in the CMS *Medicare Benefit Policy Manual*.[97] For whatever reason, the ALJ wanted the MA plan to cover the SNF stay. In a lengthy written decision that reversed the IRE, the ALJ only referenced the CMS manual and determined that the SNF should be covered since the ALJ considered the stay to be medically necessary.

2. Difficulty Understanding Medicare Law

Incredibly, many ALJs have demonstrated difficulty understanding Medicare law and then applying the law to the specific facts of appealed cases. For instance, the OIG found that some ALJs struggled interpreting the "vague definitions" contained in some Medicare policies.[98] Other ALJs indicated that they found it difficult alternating between appeals involving Parts A, B, or D of Medicare.[99] And many ALJ staff members blamed the variance in ALJ decisions on the fact that Medicare policies were not written "more narrowly or more clearly."[100]

These statements from ALJs and their staff are surprising for a couple of reasons. First, ALJs are not forced to adjudicate appeals and draft their decisions in

---

[96] *See* 42 C.F.R. §§ 409.30–.33 (2014).

[97] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE BENEFIT POLICY MANUAL, Pub. No. 100-02, Ch. 8, § 30 (2014), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf.

[98] OIG REPORT, *supra* note 2, at 11.

[99] One ALJ lamented to the OIG that "[i]n a month, I will have 10 Part A, 10 Part B, 3 Part D . . . [going] back and forth between different regulations . . . it's hard." *Id.* at 11.

[100] *Id.*

complete isolation sans support staff. Instead, OMHA provides each ALJ a support "team" to help them sift through Medicare regulations and CMS guidance.[101] Each team is comprised of an ALJ, an attorney, a paralegal, and a hearing clerk.[102] The staff attorneys and paralegals are tasked with providing the following assistance to ALJs: (i) research appeals, (ii) review and evaluate case files, (iii) prepare briefs and transcripts, (iv) assist in pre-hearing proceedings, (v) draft decisions, and (vi) provide general "assistance."[103] Plus ALJs also receive assistance from "Hearing Clerks"[104] and other "administrative support staff."[105]

Second, the majority of Medicare claims and, consequently, the majority of Medicare appeals, involve similar types of medical care, such as home health, certain DME supplies, or popular Part D drugs. ALJs should therefore be extremely well versed in adjudicating appeals that involve these common coverage areas. In addition, each ALJ decides an average of 1,220 appeals per year, based on 2013 figures.[106] It logically follows that due to sheer caseload volume, each ALJ should be intimately familiar with garden-variety Medicare claims, denials, definitions, etc., and many of the nuances associated with Medicare appeals. The commonality of claims and caseload volume should presumably lessen the concern some ALJs expressed in alternating between the different parts of Medicare.

---

[101] *See* OFFICE OF MEDICARE HEARINGS & APPEALS, FY 2012 ONLINE PERFORMANCE APPENDIX (2013) [hereinafter OMHA REPORT], at 5, *archived at* http://perma.cc/P5LA-V7GW.

[102] *Id.*

[103] 70 Fed. Reg. 36,386-04, 36,487 (June 23, 2005).

[104] "Hearing Clerks are responsible for assisting in the hearings and appeals process." *Id.*

[105] OMHA's administrative support staff are required to "provide support services to hearings operations staff, and the ALJs." *Id.*

[106] In fiscal year 2013, OMHA employed 65 ALJs, who decided a total of 79,303 appeals. This results in average of 1,220 appeals adjudicated per ALJ. Judge Nancy Griswold, *Medicare Appellant Forum*, PowerPoint slides 10-11, Washington, D.C. (February 12, 2014), [hereinafter ALJ Statistics] *archived at* http://perma.cc/RW32-ZEHG.

Granted, there are ambiguities in Medicare laws and regulations, and some CMS policies lack clarity. Due to these issues, the OIG recommended that OMHA and CMS coordinate on at least an annual basis to identify policies that are unclear.[107] CMS can then work, as needed, to develop and clarify these policies.

As a final note, although OMHA provides ALJs with support personnel, their staff does not include medical directors or clinicians. Level 2 QICs and IREs, on the other hand, have access to such medical experts. The lack of clinicians on staff certainly adds to the difficulty some ALJs may experience adjudicating appeals, particularly when the medical necessity of treatments, drugs, or supplies is at issue.[108] It also explains why the OIG found that ALJs tend to place an over emphasis on "testimony and other evidence from treating physicians."[109]

3. Judicial Bias

The most egregious issue surrounding ALJ performance involves judicial bias. The OIG found that many ALJs appear to have a pre-disposition to approve or deny appeals regardless of the merits of a claim. For instance, one ALJ stated to the OIG: "Some [ALJs] pay, some deny."[110] Another claimed, "I go towards protecting the Medicare Trust Fund[s]."[111]

The right to an impartial adjudication is a fundamental aspect of due process, and this right applies as equally in an

---

[107] OIG REPORT, *supra* note 2, at 17.

[108] Medicare specifically excludes coverage for services that are not "reasonable and necessary . . . [f]or the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 C.F.R. § 411.15(k)(1) (2014). This is generally known as Medicare's "medical necessity" standard.

[109] OIG REPORT, *supra* note 2, at 12.

[110] *Id.*

[111] *Id.* Medicare is financed through two trust funds: (1) the Federal Hospital Insurance Trust Fund (which Funds Part A), and (2) the Federal Supplementary Medical Insurance Trust Fund (which funds Part B and Part D). *See* 42 U.S.C. §§ 1395i(a), 1395t(a) (2006). These trust accounts are held by the U.S. Treasury.

administrative proceeding as it does in a court of law.[112] As relevant background, the Administrative Procedure Act of 1946 created the position of administrative law judge within the federal government.[113] The APA was passed to ensure fairness and due process in proceedings that involve adjudications by ALJs.[114] The APA requires that ALJs act "in an impartial manner" when presiding at hearings.[115] Medicare regulations are also clear on this point: "An ALJ cannot conduct a hearing if he or she is prejudiced or partial to any party or has any interest in the matter pending for decision."[116]

The Supreme Court held that bias exists when a judge demonstrates "such a high degree of favoritism or antagonism as to make a fair judgment impossible."[117] The OIG Report indicates that some ALJs have met this threshold. Because judicial bias impacts the integrity of the Medicare appeals process and prevents parties from receiving a full and fair review of their claims, OMHA must consider disciplinary action against ALJs who exhibited bias. The disciplinary action should include removal from OMHA's panel of ALJs for those who have demonstrated "systematic bias" against certain parties. [118]

---

[112] *See* Schweiker v. McClure, 456 U.S. 188, 195 (1982).

[113] Administrative Procedure Act of 1946, Pub. L. 79-404, 60 Stat. 237 (1946) [hereinafter APA]. When the APA was enacted, ALJs were called "hearing examiners." Congress changed the title to "administrative law judges" in 1978 when the APA was amended. *See* Act of Mar. 27 1978, Pub. L. 95-251, 92 Stat. 183 (1978) (amending 5 U.S.C. §§ 554(a)(2) 556(b)(3) 559, 1305, 3344, 4301, 5335, 5362, 7251 (2014)).

[114] *See* 5 U.S.C. §§ 551 *et seq* (2014).

[115] 5 U.S.C. § 556(b) (2014).

[116] 42 C.F.R. § 405.1026(a) (2011). *See* 74 Fed. Reg. 65296, 65316 (December 9, 2009) ("ALJs conduct **impartial** *de novo* hearings and this standard of review has not changed" (emphasis added.)) The Social Security Act also implicitly affirms impartial decisions for benefit applicant claims. *See* 42 U.S.C. §§ 405(b)(1); 1383(c)(1).

[117] *Liteky v. U.S.*, 510 U.S. 540, 554 (1994). *See also* Porzillo v. Dept't of Health and Human Serv., 369 Fed.Appx. 123, 129-30 (Fed. Cir. 2010).

[118] *Kendrick v. Sullivan*, 784 F.Supp. 94, 102 (S.D.N.Y. 1992) ("[A]n administrative law judge may not act in a systematically biased manner

A major difficulty here, however, is evidentiary. It is simply not easy to prove judicial bias. Even if probative evidence of bias exists, OMHA cannot unilaterally remove ALJs. OMHA must comply with Merit System Protection Board (MSPB) procedures, which include the opportunity for a hearing before the MSPB.[119]

4. Deficient Training

One reason for the dubious performance and knowledge gaps demonstrated by ALJs is deficient training. As a result of its study, the OIG felt compelled to recommend that OMHA and CMS "work together to develop and provide training on Medicare policies to ALJ and QIC staff."[120] Both agencies were charged to "provide training at least annually and focus on policies that tend to be interpreted differently by ALJs and QICs or among ALJs."[121]

OMHA's formal, written response to the OIG recommendation is puzzling. Rather than agree with the OIG, Judge Nancy J. Griswold, the current Chief Administrative Law Judge for OMHA, countered that OMHA already conducts an annual education symposium for all ALJs, in addition to "high-quality training" on Medicare law and policy for new ALJs and attorneys.[122] In terms of modifying or supplementing OMHA's current ALJ training protocol, Judge Griswold noted that OMHA is

---

in deciding cases. Rather, an administrative law judge is required to reach decisions by impartially applying the legal rules to the facts established in each case.")

[119] An in-depth discussion of the disciplinary process of the MSPB is beyond the scope of this article. Briefly, the APA allows a federal agency to take disciplinary action against an ALJ for "good cause," which must be established and determined by the MSPB. 5 U.S.C. § 7521(a) (2014). Evidence of judicial bias would certainly meet the good cause standard. In cases where bias was evident, disciplinary action against an ALJ can include removal, suspension, reduction in grade, reduction in pay, or a furlough of 30 days or less. *See* 5 U.S.C. § 7521(b) (2014). If an ALJ disagrees with an MSPB decision, it can be challenged in federal court.

[120] OIG REPORT, *supra* note 2, at 17.

[121] *Id.*

[122] *Id.* at 27.

developing a "comprehensive legal assistant training program," and that "quarterly policy updates" will be provided to ALJs and staff.[123]

Based on Judge Griswold's response, the only modification to OMHA's current training protocol for ALJs is that they will receive quarterly policy updates. Given the OIG's findings of ALJ knowledge gaps and deficiencies, this is surprising. Moreover, the Chief ALJ was already on notice about deficient ALJ training at least two years earlier. In a 2010 report, the U.S. Government Accountability Office (GAO) analyzed the hiring process for federal ALJs.[124] In the GAO Report, OMHA noted that many of its newly hired ALJs lacked the "specialized knowledge important for adjudicating cases in HHS."[125]

In the meantime, OMHA's Chief ALJ has been blissfully ignorant of the training gaps at OMHA. In a 2012 fiscal year report to HHS, for example, Judge Griswold boasted of the "cadre of knowledgeable ALJs" on staff. [126] Unfortunately, all the deficiencies that the OIG identified (i.e., erroneous decisions, difficulty understanding Medicare law, and judicial bias) will likely continue until OMHA recognizes that ALJ training and education must be significantly upgraded.

---

[123] *Id.*

[124] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO 10-14, RESULTS-ORIENTED CULTURES: OFFICE OF PERSONNEL MANAGEMENT SHOULD REVIEW ADMINISTRATIVE LAW JUDGE PROGRAM TO IMPROVE HIRING AND PERFORMANCE MANAGEMENT (2010) [hereinafter GAO Report]. The GAO Report was based on an analysis of ALJs from the Social Security Administration and HHS.

[125] *Id.* at 10.

[126] OMHA REPORT, *supra* note 102, at 1. CMS also apparently believes that the status quo is acceptable for ALJ training. In a 2009 HHS final rule, CMS asserted that ALJs receive "significant and comprehensive training" about Medicare statutes and regulations after they are hired. 74 Fed. Reg. 65,296, 65,315-316 (Dec. 9, 2009). Through this extensive training, CMS asserts that ALJs are armed with the "knowledge and expertise necessary to address the highly complex and technical issues associated with Medicare claims appeals." *Id.* at 65,136.

B. Handling Fraud

In the course of processing and adjudicating appeals, ALJs and their staff often come across evidence indicating a party may have committed fraud against the government. In fact, nearly all ALJ staff reported to the OIG that they suspected fraudulent activity by parties involved in appeals.[127] Despite these suspicions, many staff members acknowledged that during their tenure with OMHA they had never made a single fraud referral.[128] Others claimed to have made at least one referral.

Overall, a culture of silence appears to predominate OMHA offices when employees are faced with the opportunity to report fraud. Some staff candidly admitted to the OIG that they declined to make fraud referrals because they did not consider it a part of their job duties.[129] Two quotes from different ALJ staff members are telling: (1) "[I] never referred and do not want to refer anything . . . [it is] not our business here"; and (2) "[T]here is an unspoken rule not to report fraud."[130]

Due to this spotty record of fraud reporting, the OIG recommended that OMHA "develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly."[131] Judge Griswold, OMHA's Chief ALJ, issued a formal response to the OIG Report and its fraud recommendation. Judge Griswold countered that:

> OMHA has conducted anti-fraud training sessions in conjunction with the OIG and CMS. OMHA staff has been informed how to report suspicions of fraud regarding an appeal. OMHA continues to develop policies aimed at providing guidance to ALJs and their staff

---

[127] OIG REPORT, *supra* note 2, at 15.

[128] *Id.* OMHA employees, including ALJs and their staff, would generally report Medicare fraud to either the HHS Office of Inspector General (the same OIG that conducted the present study of ALJs) or the U.S. DOJ.

[129] *Id.*

[130] *Id.*

[131] *Id.* at 19.

> with respect to handling suspicions of fraud. . . . OMHA maintains frequent contact with a designated OIG Office of Investigations contact at the national level and has made several fraud referrals.[132]

Judge Griswold's response is quite remarkable in what it fails to address. First, it includes no indication of whether the anti-fraud training and fraud reporting is mandatory for all OMHA employees, including ALJs. Second, Judge Griswold neglects to indicate the frequency of the training.[133] Third, there is no mention if OMHA maintains a verification or certification process to ensure that all employees and ALJs attend the training. Fourth, Judge Griswold claims that her entire department has made "several" fraud referrals, with no mention of quantity or timeframe.[134] Because OMHA provided no actual figures on how many suspected cases of fraud were reported, one can reasonably assume the number is quite low. Finally, Judge Griswold states that ALJ staff received anti-fraud training and was informed "how" to report fraud. But as the OIG indicated, the problem is not that OMHA employees do not know where or how to report fraud; the problem is that some staff feel they have no affirmative duty whatsoever to identify and report fraud.

OMHA's apathetic handling of suspected cases of fraud is clearly lacking. Hence the directive from the OIG that OMHA "[d]evelop policies to handle suspicions of fraud appropriately and consistently and train staff

---

[132] *Id.* at 29-30.

[133] For example, there is no indication whether the training is required only at the time of hiring (i.e., "one-and-done" training), or if it is an annual, recurring requirement for all employees.

[134] Judge Griswold's claim here leads to numerous, legitimate questions of the time period involved when the fraud referrals occurred. For instance, did OMHA make "several" (i.e., more than two) fraud referrals during the same week that Judge Griswold wrote her letter? Or has OMHA made "several" (i.e., more than two) referrals over the past five years?

accordingly."[135] Furthermore, OMHA's shortcomings are significant when one considers (1) the fraud policy of the Obama administration; (2) whether the failure to report fraud is grounds for termination of employment; and (3) the fraud-reporting obligations that CMS imposes on private entities involved in Medicare. This section will address each of these areas.

1. Obama Administration

The checkered fraud-reporting record of ALJs and their staff runs counter to the express policy of the Obama administration. This policy is evidenced through official statements, an Executive Order, and legislation. Prior to President Barack Obama's first inauguration in 2009, for example, the Obama-Biden transition team emphasized the importance of ethics in the federal government. The transition team stated:

> Often the best source of information about waste, fraud, and abuse in government is an existing government employee committed to public integrity and willing to speak out. Such acts of courage and patriotism, which can sometimes save lives and often save taxpayer dollars, should be encouraged rather than stifled. We need to empower federal employees as watchdogs of wrongdoing and partners in performance. Barack Obama will strengthen whistleblower laws to protect federal workers who expose waste, fraud, and abuse of authority in government. [136]

The U.S. Department of Justice (DOJ) under President Obama has also echoed the refrain that federal employees have an obligation to help root out corruption in government and protect taxpayer dollars. In a 2009

---

[135] OIG REPORT, *supra* note 2, at 19.

[136] Agenda - Ethics, Change.gov, *archived at* http://perma.cc/YN43-YRAR.

statement to the House of Representatives on proposed whistleblower legislation, the DOJ noted that "the best source of information about waste, fraud, and abuse in government is often a government employee committed to public integrity and willing to speak out."[137] Federal employees, the DOJ added, should serve as "stewards of accountability due to their unique position to observe fraud against the government." [138]

In harmony with these statements, President Obama signed an Executive Order on ethics on his first full day in office on January 21, 2009.[139] The Order is titled "Ethics Commitment by Executive Branch Personnel."[140] In addition to a ban on gift-giving from lobbyists, it requires "every appointee in every executive agency" to sign an "Ethics Pledge."[141] Also in November 2012, President Obama signed the Whistleblower Protection Enhancement Act (WPEA).[142] The WPEA built on previous legislation to strengthen and extend whistleblower protections to federal employees who report "gross mismanagement, a gross waste of funds, [or] an abuse of authority."[143]

2. Federal Law

Federal law requires employees of the federal government to report fraud. In 1990 President George H. W. Bush signed an Executive Order entitled "Principles of Ethical Conduct for Government Officers and Employees," which outlined fourteen principles of ethical conduct for

---

[137] *Protecting the Public from Waste, Fraud, and Abuse: H.R. 1507, The Whistleblower Protection Enhancement Act of* 2009: *Hearing Before the H. Comm. on Oversight and Govt. Reform*, 111th Cong. 1 (2009) (statement of Rajesh De, Deputy Assistant Att'y Gen., U.S. Dep't of Justice).

[138] *Id.* at 2.

[139] Exec. Order No. 13,490, 74 Fed. Reg. 4,673 (January 26, 2009).

[140] *Id.*

[141] *Id.* at 4,673

[142] Whistleblower Protection Enhancement Act of 2012, Pub. L. No. 112-199, 126 Stat. 1465 (2012) [hereinafter WPEA].

[143] *Id.* at § 102

government employees.[144] These principles were later issued as regulations by the Office of Government Ethics, and are formally known as the *Standards of Ethical Conduct for Employees of the Executive Branch*.[145] The *Ethical Standards* "apply to every employee" in federal government,[146] and all employees are required to "respect and adhere" to them.[147] Three of the fourteen principles are of particular relevance here:

> No. 8 "Employees shall act impartially and not give preferential treatment to any private organization or individual."[148]
>
> No. 11 "Employees shall disclose waste, fraud, abuse, and corruption to appropriate authorities."[149]
>
> No. 14 "Employees shall endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards set forth in this part. Whether particular circumstances create an appearance that the law or these standards have been violated shall be determined from the perspective of a reasonable person with knowledge of the relevant facts."[150]

---

[144] Exec. Order No. 12,731, 55 Fed. Reg. 42,547 (October 19, 1990).

[145] Basic Obligation of Public Service, 5 C.F.R. § 2635.101 (2014) [hereinafter *Ethical Standards*] The *Ethical Standards* are based on the notion that "[p]ublic service is a public trust." *Id.* at § 2635.101(a).

[146] 5 C.F.R. § 2635.101(b) (2014).

[147] 5 C.F.R. § 2635.101(a) (2014).

[148] 5 C.F.R. § 2635.101(b)(8) (2014).

[149] 5 C.F.R. § 2635.101(b)(11) (2014). Pursuant to this provision, the U.S. Environmental Protection Agency states that federal employees are "duty bound to report Fraud, Waste, Abuse, and Corruption." OFFICE OF INSPECTOR GEN., EPA, FRAUD, WASTE AND ABUSE: PREVENTION, DETECTION, AND REPORTING FOR FEDERAL, STATE, LOCAL, AND TRIBAL ADMINISTRATORS, *archived at* http://perma.cc/E9PV-W4GL.

[150] 5 C.F.R. § 2635.101(b)(14) (2014).

ALJs have not only violated these principles, but many appear to act with a deliberate disregard of their duty to disclose fraud when they become aware or suspicious of it. A violation of any one of the *Ethical Standards* is prima facie evidence that an individual has "engaged in conduct unbecoming a federal employee."[151] Since 1998, federal employees across several government agencies, including HHS, have been fired or suspended for violating these standards.[152] HHS regulations, incidentally, also require HHS employees to immediately report any cases of fraud, waste, or abuse that they become aware of.[153]

Based solely on the OIG interviews of ALJ staff, it is impossible to quantify the percentage of ALJs and staff who suspected fraudulent activity but violated the *Ethical Standards* by not reporting it. But in a government agency with approximately 514 employees[154] and that processed 79,303 appeals in 2013,[155] it is certainly reasonable to assume that minimally dozens of OMHA employees were exposed to fraudulent activity by parties involved in appeals. Yet despite a legal and ethical obligation to report Medicare fraud, it is not occurring.

---

[151] *See* Schifano v. Dep't of Veterans Affairs, 70 M.S.P.B. 275, 281 (1996).

[152] *See*, *e.g.*, U.S. v. Project on Gov't Oversight, 839 F.Supp.2d 330 (D.D.C. 2012); U.S. v. Safavian, 451 F.Supp.2d 232 (D.D.C. 2006); Suarez v. Dep't of Housing and Urban Dev., 96 M.S.P.B. 213 (2004), *aff'd*, 125 Fed.Appx. 1010 (Fed. Cir. 2005); and Mann v. Dep't of Health and Human Serv., 78 M.S.P.B. 1 (1998).

[153] *See* 45 C.F.R. § 73.735-1302 (2014) ("An employee who has information which he or she reasonably believes indicates . . . mismanagement, a gross waste of funds, or abuse of authority . . . shall immediately report such information to his or her supervisor . . . or directly to the Office of Inspector General.")

[154] *See* S. 1284, 113th Cong. § 112 (2014) (figure based on 2014 appropriations).

[155] *See* ALJ Statistics, *supra* note 10.

3. Fraud-Reporting Requirements For Private Entities Involved in Medicare

The lax commitment by ALJs toward identifying and reporting fraud against the government stands in vivid (as well as ironic) contrast to the standards CMS imposes on private companies involved in Medicare's Part C (Medicare Advantage) and Part D (prescription drug) programs. Both CMS and OMHA are affiliate government agencies that report directly to HHS. CMS is responsible for oversight of entities offering Medicare Advantage and prescription drug plans. In this capacity, CMS currently requires every "sponsor" of these plans to implement a Medicare "compliance program."[156]

In order to pass CMS muster, a compliance program must minimally include the following components that are related to fraud:

- Sponsors must report "actual or suspected" cases of fraud;[157]

---

[156] *See* 42 C.F.R. §§ 422.503(b)(4)(vi), 423.504(b)(4)(vi) (2014). *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T. OF HEALTH AND HUMAN SERVS., MEDICARE MANAGED CARE MANUAL, Pub. No. 100-16, ch. 21 (2013) [hereinafter MMCM], *archived at* http://perma.cc/WM3W-2Z38; MEDICARE & MEDICAID SERVS., U.S. DEP'T. OF HEALTH AND HUMAN SERVS., PRESCRIPTION DRUG BENEFIT MANUAL, Pub. No. 100-18, ch. 9 (2013) [hereinafter PDBM], *archived at* http://perma.cc/8C38-ZGDW.

[157] MMCM, *supra* note 157, at § 50.3.1; PDBM, *supra* note 157, at § 50.3.1. CMS also mandates that fraud training includes instruction on identifying and reporting "waste" and "abuse." CMS describes "waste" as "the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources." MMCM, § 20; PDBM, § 20. "Abuse" is described as "actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented the facts to obtain payment." *Id.*

- Employees involved in administering Part C or Part D benefits must receive fraud training within 90 days of initial hire and annually thereafter from plan sponsors. And sponsors must be able to demonstrate to CMS that their employees received this training through sign-in sheets, employee attestations, or electronic certification;[158]
- Sponsors must provide fraud training directly to entities that provide treatment to Medicare enrollees, such as hospitals, physicians, or skilled nursing facilities;[159] otherwise sponsors can provide fraud training materials to these entities;
- Written policies and procedures that require their employees and corporate officers to report "suspected or actual" fraud violations and compliance concerns;[160]
- Whistleblower protection that apply to any employee who reports fraud "in good faith";[161] and
- Sponsors must maintain a tracking system to follow any reports of "suspected or detected" incidents of fraud.[162]

All of these standards are issued as mandates from CMS. Failure to implement an adequate compliance program can result in CMS fines, sanctions, or even a ban or prohibition on offering a Medicare program. With such

---

158 MMCM, *supra* note 157, at § 50.3.2; PDBM, *supra* note 157, at § 50.3.2. *See also* 42 C.F.R. § 422.503(b)(4)(vi)(C) (2014).

159 MMCM, *supra* note 157, at § 50.3.2; PDBM, *supra* note 157, at § 50.3.2. (CMS also requires training on other federal laws, such as the Health Insurance Portability and Accountability Act, the False Claims Act, the Anti-Kickback statute, and the Physician Self-Referral law).

160 MMCM, *supra* note 157, at § 50.4.2; PDBM, *supra* note 157, at § 50.4.2.

161 MMCM, *supra* note 157, at § 50.4.2; PDBM, *supra* note 157, at § 50.4.2.

162 MMCM, *supra* note 157, at § 50.4.2; PDBM, *supra* note 157, at § 50.4.2.

robust fraud-reporting requirements for employees of Medicare Advantage and Part D plans, it is nonsensical that OMHA does not impose such affirmative obligations on its ALJs and staff. In fact, CMS even requires its own adjudicators of redeterminations to "deny or reduce payment" when they believe items or services were not rendered or were not rendered as billed.[163]

4. Deterrent Effect of Fraud Reporting

Perhaps lost in this discussion of the failure by ALJs and their staff to report fraud is consideration of the deterrent effect of fraud reporting. Health care fraud is a national dilemma. It is estimated that Medicare fraud alone costs the program between $60 billion and $90 billion each year.[164] Medical providers and suppliers who are attempting to game the system with fraudulent claims will be less likely to appeal denials if they are aware that ALJs and their staff will diligently report any cases of suspected fraud.

Millions of dollars could potentially be saved if providers stopped pushing bogus medical claims through the appeals system because they realized they were likely to be reported. In fiscal year 2012 alone, the federal government won or negotiated over $3 billion in health care fraud judgments and settlements.[165] From these recoveries, $2.4 billion dollars were transferred back into the Medicare Trust Funds.[166] ALJs can and must play a greater role in deterring Medicare fraud by fulfilling their reporting obligations.

---

[163] *See* MCPM, *supra* note 29, at § 280.4.

[164] Jim Suhr, *Report: Health Care Fraud Cases Hit High Last Year*, YAHOO (Jan. 15, 2014), http://perma.cc/28Q9-FM64.

[165] U.S. DEP'T OF HEALTH & HUMAN SERVS. & DEP'T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: ANNUAL REPORT FOR FISCAL YEAR 2012 1 (2013), *archived at* http://perma.cc/S53L-X6TQ.

[166] *Id.* at 8.

C. Appeal Record

During the course of an appeal in any adjudicatory proceeding, it is critical that an appeal record be logically compiled and organized for the parties and the adjudicator. From its study, the OIG found that ALJ staff often received "incomplete or disorganized" appeal files from Qualified Independent Contractors (QICs) during Level 2 appeals.[167] Deficient appeal files, in turn, led to delays and "inefficiencies" in the appeals process since ALJs were forced to remand the appeals to QICs, request additional information, or reorganize the case files.[168]

One major weakness with Medicare's appeals process is that QIC appeal files are organized and processed electronically, while OMHA's ALJs only accept paper files. The process for QICs to convert electronic files to a paper format is resource intensive and prone to error. To remediate this problem, the OIG recommended that OMHA and CMS make case files "more consistent" through the various Medicare appellate levels.[169] The OIG felt this could be accomplished by finalizing and enforcing a Memorandum of Understanding (MOU) between the two departments that specifies how case files are organized.[170] The OIG also recommended that OMHA "accelerate" an initiative to transition from paper to electronic files.[171]

1. Records Forwarded to the Medicare Appeals Council

Poorly-managed case files are a major problem for ALJs. But the OIG Report did not fully explore the depth and breadth of this issue. The OIG focused primarily on the condition of the appeal record that ALJs receive *from* QICs. But a similar, if not greater, problem exists with the content and organization of the appeal files that ALJs forward to the Level 4 Medicare Appeals Council (MAC). As evidence,

---

167 OIG REPORT, *supra* note 2, at 14.

168 *Id.*

169 *Id.* at 18.

170 *Id.*

171 *Id.*

one can access countless cases that were appealed to the MAC, but that could not be adjudicated due to the utter disarray of ALJ appeal files. The appeal record is of critical importance during a Level 4 appeal since the MAC must decide each appeal "on the record" (i.e., without a hearing).[172]

A snapshot of this problem is found in a 2009 MAC case that involved a rather straightforward issue of whether a physician who had been excluded from federal health care program participation was eligible to be reimbursed by Medicare.[173] The appeal record that the ALJ forwarded in this case to the MAC was so deficient that the MAC was precluded from making any specific citation to the appeal record. The ALJ essentially forwarded an appeal record that appeared to be a quick dump of a case file. The MAC's description of the appeal record is comical:

> [T]he record in this case is in disarray. In its current state, the record consists of ten large manila folders, secured only by rubber bands, containing unbound documents neither paginated nor more than generically indexed. The documentation itself includes pages which are in no apparent sequential order, folded, upside down, and/or blank side up, envelopes, parts of envelopes as well as a diskette in an unsecured envelope purporting, based on the writing on the diskette, to be a 'QIC copy' of a 'correction to letter.' The ALJ's reference to the exhibits in his Order is no clearer, simply consisting of twenty-three footnote citations to 'Exhs. Appendix A.'[174]

---

[172] There are some limited exceptions, however. The MAC will permit hearings for appeals that raise important issues of law, policy, or facts that can't be determined solely from the record. *See* 42 C.F.R. § 405.1124 (2014).

[173] *See In re* Breton Morgan, M.D., 2009 WL 5764312 (M.A.C. Nov. 5, 2009).

[174] *Id.* at *4 (footnote omitted).

Due to the shoddy and cluttered state of the appeal record, the MAC remanded the case to the ALJ, along with detailed instructions on how to organize the record. The MAC felt compelled to instruct the ALJ to "[c]hronologically organize, secure, paginate and index all exhibits admitted as evidence in the record"; and to "[i]dentify, organize, secure, paginate and index the documentation submitted with the appellant's request for an ALJ hearing, which the ALJ directed should be excluded."[175]

One would not expect these elementary instructions from the MAC to be necessary. But this case was not an anomaly. In a 2010 appeal, for example, the MAC was precluded from adjudicating an appeal because it was unable to retrieve a complete appeal record from the ALJ.[176] Specifically, "Exhibit 7" was missing from the record. The MAC's narrative of the situation borders on the absurd:

> The ALJ's Exhibit List identifies Exh. 7 as a 'binder.' There is no binder in any of the exhibit boxes provided to the Council. In an effort to obtain the missing exhibit, the office contacted [OMHA] and was informed that Exh. 7 may have been recorded on multiple CDs. While the record contains a single CD identified only as 'ALJ # 1-474904598***' with 'AdvanceMed Corporation' on the right side of the disk, it is not marked as Exhibit 7 nor does it contain multiple CDs. . . . This CD was provided to the Council after the remainder of the case record was received. In any event, in attempting to review the contents of the CD, a message appeared indicating that the disk was encrypted; the message stated the name of the person at AdvanceMed to contact for the password. Efforts were made to obtain the password from the appellant, but this office

---

[175] *Id.* at *5-6.

[176] *See* Felicia Sankey, M.D., No. M-10-856, 2010 WL 7342938 (M.A.C. Dec. 17, 2010).

> was informed that the contact person was no longer employed by the appellant and that no one else would have that information. Thus, the Council has not been able to ascertain whether the information on this CD consists of part or all of Exhibit 7.[177]

The ineptitude demonstrated by ALJs and staff when compiling and forwarding the appeal record is certainly not limited to these two cases. A Westlaw query yields a seemingly endless number of remands to the ALJ because the MAC could not view or retrieve the appeal record.[178] Due to the frequency of these remands, the MAC uses cut-and-paste boilerplate in its orders indicating that a deficient appeal record prevented them from issuing a decision. Organized and comprehensive appeal records are clearly critical to ensure that parties have appeals decided in a timely manner. The OIG therefore overlooked a significant

---

[177] *Id.* at *1, n. 1 (citation omitted).

[178] *See, e.g.,* Robert W. Levin, M.D., No. M-12-433, 2012 WL 3067972 (M.A.C. May 16, 2012); A Fitting Experience Mastectomy Shoppe, No. M-12-1222, 2012 WL 4482710 (M.A.C. Aug. 23, 2012); Jewish Hospital & St. Mary's Healthcare, No. M-12-960, 2012 WL 4482737 (M.A.C. Aug. 24, 2012); MassHealth & N.Y. Office of Medicaid Inspector Gen., No. M-12-1108, 2012 WL 6066035 (M.A.C. Sept. 7, 2012); Gordian Medical, Inc., No. M-11-2723, 2012 WL 4358991 (M.A.C. Aug. 10, 2012); Prima Care Medical Group, M-11-567, 2012 WL 1980616 (M.A.C. Mar. 23, 2012); Advance Diabetes Treatment Centers, No. M-10-1376, 2012 WL 1793277 (M.A.C. Mar. 5, 2012); Int'l Rehabilitative Scis., Inc., No. M-11-1220, 2012 WL 3164410 (M.A.C. May 31, 2012); Kingston of Ashland, No. M-11-765, 2011 WL 6960310 (M.A.C. May 20, 2011); Sunrise Family Foot Care Ctr., No. M-11-976, 2011 WL 6025971 (M.A.C. Mar. 7, 2011); M.A.B., No. M-10-1206, 2011 WL 5080370 (M.A.C. Feb. 10, 2011); Bionicare Med. Techs., Inc., No. M-09-414, 2011 WL 7102455 (M.A.C. Sept. 7, 2011); Mane Med. Equip. & Supplies, Inc., No. M-10-1425, 2011 WL 3668258 (M.A.C. Jan. 13, 2011); H.R., No. M-11-1867, 2011 WL 7145355 (M.A.C. Oct. 11, 2011); West Universal Rehab, No. M-11-221, 2011 WL 6968104 (M.A.C. July 8, 2011); L.J.K., No. M-10-1745, 2010 WL 7342928 (M.A.C. Dec. 17, 2010); J.A.C., No. M-10-1386, 2010 WL 7209415 (M.A.C. Nov. 17, 2010); Kinetic Concepts, Inc., No. M-2009-884, 2010 WL 2831009 (M.A.C. Feb. 25, 2010); Int'l Rehabilitation Scis., Inc., No. M-10-1970, 2010 WL 7342932 (M.A.C. Dec. 17, 2010).

issue that requires remediation when it failed to analyze the appeal records that ALJs forward to the MAC.

V. CONCLUSION

The OIG was successful in identifying numerous deficiencies with Medicare's ALJs and the third level of Medicare appeals. But the OIG Report failed to adequately address the magnitude of the deficiencies and the appropriate remedial action necessary to correct them. The core problem involves the competency and performance of the ALJs themselves. OMHA's panel of ALJs includes judges who are simply not fit to hold hearings and adjudicate appeals. If ALJs exhibit bias, disregard binding authority, or have (with any modicum of experience) difficulty understanding Medicare laws and regulations, then those individuals should simply not serve as triers of fact and decision-makers.

Part of the problem lies at the feet of the Office of Personnel Management (OPM). OPM should not send ALJ candidates to OHMA who have little, if any, prior experience with Medicare. But OMHA merits a greater amount of culpability for providing substandard training and follow-up for the ALJs who are already on staff, and OMHA must accept responsibility for keeping ALJs on panel who have demonstrated bias against specific types of individuals or parties. OMHA must attempt to identify these ALJs, and then initiate the appropriate process with the Merit Systems Protection Board to discipline or remove them.[179] Medicare enrollees, plan sponsors, providers and suppliers deserve nothing less than fair and impartial adjudications.

OMHA must also develop better fraud training and require ALJs and staff to attend training at the time of hire and at least annually thereafter. Many ALJs simply do not understand nor accept their fraud-reporting obligations. As employees of HHS, they must recognize that they are stewards of the Medicare Trust Funds, and they must be

[179] *See* 5 U.S.C. § 556(b) (2014).

perceptive of individuals who are depleting these funds through fraudulent and abusive schemes. Finally, OMHA must assist with, rather than hinder, the efficiency of Medicare's appeals process. This can be accomplished by improving its internal controls and forwarding only formatted and complete appeal records to the Medicare Appeals Council (MAC).