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OFFICE OF INSPECTOR GENERAL

IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS

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EXECUTIVE SUMMARY: IMPROVEMENTS ARE NEEDED AT THE ADMINISTRATIVE LAW JUDGE LEVEL OF MEDICARE APPEALS
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WHY WE DID THIS STUDY

Administrative law judges (ALJ) within the Office of Medicare Hearings and Appeals (OMHA) decide appeals at the third level of the Medicare appeals system. In 2005, among other changes, ALJs were required to follow new regulations addressing how to apply Medicare policy, when to accept new evidence, and how the Centers for Medicare & Medicaid Services (CMS) participates in appeals. Medicare providers and beneficiaries may appeal certain decisions related to claims for health care services and items.

HOW WE DID THIS STUDY

We based this study on an analysis of all ALJ appeals decided in fiscal year (FY) 2010; structured interviews with ALJs and other staff; structured interviews with Qualified Independent Contractors (QIC), which administer the second level of appeal, and CMS staff; policies, procedures, and other documents; and data on CMS participation in ALJ appeals.

WHAT WE FOUND

Providers filed the vast majority of ALJ appeals in FY 2010, with a small number accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed QIC decisions and decided in favor of appellants; this rate varied substantially across Medicare program areas. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. In addition, the favorable rate varied widely by ALJ. When CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. Staff raised concerns about the acceptance of new evidence and the organization of case files. Finally, ALJ staff handled suspicions of fraud inconsistently.

WHAT WE RECOMMEND

We recommend that OMHA and CMS: (1) develop and provide coordinated training on Medicare policies to ALJs and QICs, (2) identify and clarify Medicare policies that are unclear and interpreted differently, (3) standardize case files and make them electronic, (4) revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence, and (5) improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary. Further, we recommend that OMHA: (6) seek statutory authority to establish a filing fee, (7) implement a quality assurance process to review ALJ decisions, (8) determine whether specialization among ALJs would improve consistency and efficiency, and (9) develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly. Finally, we recommend that CMS: (10) continue to increase CMS participation in ALJ appeals. OMHA and CMS concurred fully or in part with all 10 of our recommendations.

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OBJECTIVES

1. To describe the characteristics of appeals decided by Medicare administrative law judges (ALJ) in fiscal year (FY) 2010.
2. To describe differences between ALJ and prior-level decisions and differences among ALJs.
3. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) participated in ALJ appeals in FY 2010.

BACKGROUND

Medicare providers and beneficiaries may appeal certain decisions related to claims for health care services and items.[1] The administrative appeals process includes four levels; ALJs decide appeals at the third level. In 2005, the responsibility for conducting ALJ appeals was transferred from the Social Security Administration (SSA) to the Department of Health and Human Services (HHS).[2]

Among other changes, ALJs were required to follow new regulations that addressed how Medicare policy must be applied, when new evidence may be accepted, and how CMS can participate in appeals.[3] Before these changes were introduced, two Office of Inspector General (OIG) reports found a number of problems with Medicare appeals.[4] In particular, OIG found that the different levels of appeal did not consistently apply the same standards and that CMS's ability to defend its decisions was limited. The 2005 regulatory changes were intended to address many of these concerns.

This report is the first to assess the impact of these changes on ALJ appeals. In particular, it describes the characteristics of appeals decided by ALJs, differences between ALJ and prior-level decisions, differences among ALJs, and CMS's participation in ALJ appeals.

The Medicare Administrative Appeals Process

There are four levels of appeal:

- Level One, administered by CMS Medicare Administrative Contractors;

[1] For the purposes of this report, we use "provider" to refer to both providers and suppliers that provide items and services under Medicare Parts A and B.

[2] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173 § 931.

[3] 42 CFR §§ 405.1010, 405.1012, 405.1028, and 405.1062(a).

[4] OIG, *Medicare Administrative Appeals: ALJ Hearing Process*, OEI-04-97-00160, September 1999; OIG, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-00290, January 2002.

- Level Two, administered by CMS Qualified Independent Contractors (QIC);
- Level Three, administered by ALJs; and
- Level Four, administered by the Medicare Appeals Council.[5]

When a party is dissatisfied with CMS's payment decision on a claim, that party may appeal. The party that files an appeal is called the appellant. If appellants receive unfavorable decisions at one level, they may appeal to the next level.[6] Appellants include Medicare beneficiaries; Medicare providers, such as physicians, suppliers, and hospitals; and State Medicaid agencies. State Medicaid agencies may appeal when there is a question of whether Medicare, rather than Medicaid, should pay for the services or items received by beneficiaries who are eligible for both Medicare and Medicaid coverage (known as dually eligible beneficiaries).

The first level of appeal is administered by the CMS contractors that make the initial decisions to pay or deny claims.[7] At the second level, two QICs conduct Part A appeals; two conduct Part B appeals; and one conducts appeals for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). At the first two levels, decisions are made after the contractors review the evidence in the case files.[8]

The third level of appeal is conducted by ALJs and differs substantially from the first two levels. One of the major differences is that the appellant has the right to a hearing before an ALJ. Under certain circumstances, however, the ALJ may not conduct a hearing and instead may make a decision after reviewing the evidence in the case file (known as an on-the-record review).[9]

An ALJ may make a decision that is fully favorable, partially favorable, or unfavorable to the appellant.[10] These decisions must be based on evidence in the

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[5] The third and fourth levels apply to most types of appeals, but the first two levels apply only to appeals related to Medicare Parts A and B claims.

[6] The first two levels of appeal do not require a minimum dollar amount to be at issue, but the ALJ level does. In FY 2010, this threshold was $130. See 42 CFR § 405.1006. None of the levels of appeal require appellants to pay a filing fee.

[7] Of the 1.1 billion Parts A and B claims that CMS contractors processed in 2010, 117 million were denied and 2.7 million were appealed to the first level. See CMS, Fact Sheet: Original Medicare (Fee-For-Service) Appeals Data – 2010. Accessed at https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Factsheet2010.pdf on August 8, 2012.

[8] The case file refers to the administrative record and includes claims, medical records, and other evidence. See 42 CFR § 405.1044(b).

[9] An ALJ may make a decision after an on-the-record review if the parties waive their right to a hearing or if the evidence supports a fully favorable decision for the appellant. See 42 CFR §§ 405.1000(e)–(g). See also 42 CFR § 405.1038.

[10] Under certain circumstances, an ALJ may also dismiss an appeal or remand it to the prior level. See 42 CFR §§ 405.1034 and 405.1052.

case files and on hearing testimony.[11] The law protects ALJs' independence to ensure that their decisions are impartial and free from HHS influence.[12] Any party who is dissatisfied with the ALJ's decision may appeal to the Medicare Appeals Council. When deciding appeals, adjudicators at all four levels conduct a new, independent review of the evidence and are not bound by the prior levels' findings and decisions.[13] After exhausting the four levels of the administrative appeals process, parties may seek judicial review in Federal District Court.

Changes to Medicare ALJ Appeals

In 2005, HHS established the Office of Medicare Hearings and Appeals (OMHA), which created a group of ALJs dedicated to deciding Medicare appeals. These ALJs were required to follow new regulations that addressed how Medicare policy must be applied, when new evidence may be accepted, and how CMS may participate in appeals.

Prior to 2005, ALJs were bound by Medicare laws, regulations, and National Coverage Determinations when making decisions, but were not bound by Local Coverage Determinations or CMS program guidance. In 2005, new regulations were introduced that required ALJs to "give substantial deference" to these latter policies and to provide an explanation if they decline to follow one of these policies in an appeal.[14]

Prior to 2005, appellants were allowed to submit new evidence at the ALJ level without restrictions. Beginning in 2005, an appellant must explain in writing the reason for submitting new evidence and ALJs may accept the new evidence only if they determine that the appellant had "good cause" for waiting until the ALJ level to submit it.[15]

Before 2005, CMS was not allowed to participate in ALJ appeals, which were established as a nonadversarial system for appellants to present their cases before neutral judges.[16] Under the new regulations, however, CMS may choose to participate in ALJ appeals as either a participant or a party. As a participant, CMS

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[11] 42 CFR § 405.1046(a).

[12] 5 U.S.C. § 554(d).

[13] This type of review is referred to as *de novo*. See CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 29, § 110; 42 CFR §§ 405.948, 405.968(a)(1), 405.1000(d), and 405.1100(c).

[14] 42 CFR § 405.1062(a)–(b). Prior to these regulations, Federal case law established that adjudicators should give deference to agency guidance, such as Local Coverage Determinations. See Shalala v. Guernsey Memorial Hospital, 514 US 87 (1995). QICs are also bound by Medicare laws, regulations, and National Coverage Determinations and must give substantial deference to Local Coverage Determinations and CMS program guidance. See 42 CFR § 405.968(b).

[15] 42 U.S.C. § 1395ff(b)(3). This restriction applies to providers and represented beneficiaries, but not to unrepresented beneficiaries. It also does not apply to oral testimony presented during the hearing. See 42 CFR §§ 405.1018(c) and 405.1028.

[16] Before 2005, CMS participated occasionally when an ALJ requested its participation. See 70 Fed. Reg. 11459 (Mar. 8, 2005).

may submit position papers and provide testimony during the hearing.[17] As a party, CMS may also submit evidence to the ALJ, call or cross-examine witnesses during the hearing, and appeal to the next level.[18] CMS contractors, rather than the agency, typically participate in ALJ appeals.

Related Work

This report is part of OIG's continuing work on Medicare ALJ appeals. Two OIG reports evaluated ALJ appeals when they were administered by SSA.[19] These reports found that the different levels of appeal did not consistently apply the same standards and that CMS's ability to defend its decisions was limited. OIG recommended requiring the different levels of appeal to apply the same standards, creating a dedicated ALJ corps for Medicare, and allowing increased participation from CMS at the ALJ level.

In addition, two OIG reports evaluated ALJ appeals after the transition from SSA to OMHA.[20] These reports were focused on the timeliness of ALJ appeals and on the format of ALJ hearings, which included, for the first time, telephone and video teleconference hearings in addition to the in-person hearings used by SSA. The reports found that OMHA did not decide a number of its cases in a timely manner during its first 13 months of operation, but that timeliness improved by its third year of operation. In addition, OIG found that most appellants who were interviewed were satisfied with their hearing formats.

METHODOLOGY

We based this study on an analysis of: (1) data on appeals decided in FY 2010; (2) structured interviews with ALJs and other OMHA staff; (3) structured interviews with QIC and CMS staff; (4) policies, procedures, and other documents; and (5) data on CMS participation in ALJ appeals.

Appeals Data

We obtained data on ALJ appeals from the Medicare Appeals System (MAS), a database that tracks appeals at the second and third levels. Using these data, we examined several characteristics of the appeals decided by ALJs in FY 2010.

We calculated the percentage of ALJ appeals for each appellant type—beneficiaries, providers, and State Medicaid agencies. We determined whether

[17] 42 CFR § 405.1010(c).

[18] 42 CFR § 405.1012.

[19] OIG, *Medicare Administrative Appeals: ALJ Hearing Process*, OEI-04-97-00160, September 1999; OIG, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-00290, January 2002.

[20] OIG, *Medicare Administrative Law Judge Hearings: Early Implementation, 2005–2006*, OEI-02-06-00110, July 2008; OIG, *Medicare Administrative Law Judge Hearings: Update, 2007–2008*, OEI-02-06-00111, January 2009.

the different types of appellants were more likely to file appeals related to certain Medicare program areas (e.g., Part A hospital appeals).[21] We also calculated the number of appeals associated with each unique appellant and identified the appellants who filed frequently.[22] We considered appellants to be frequent filers if they had 50 or more appeals decided in FY 2010.

Next, we calculated the percentage of appeals associated with each type of ALJ decision: fully favorable to the appellant, partially favorable to the appellant, unfavorable to the appellant, or other.[23] In addition, we determined the extent to which the fully favorable rate varied by Medicare program area and by appellant type.

We then analyzed how the fully favorable rate varied by ALJ.[24] We determined whether the variation in fully favorable rates was associated with some ALJs' deciding more appeals in certain Medicare program areas than other ALJs. To conduct this analysis, we compared each ALJ's actual fully favorable rate to that ALJ's expected fully favorable rate.[25] In addition, we determined the extent to which frequent filers received different favorable rates from different ALJs. Finally, we determined whether certain ALJs were more likely than others to decide appeals after an on-the-record review of the case file.

We also obtained data from MAS on appeals that QICs decided in FY 2010. We used these data to calculate the percentage of QIC appeals that were fully favorable to appellants.

Structured Interviews With ALJs and Other OMHA Staff

We conducted structured interviews with the Chief ALJ, the Executive Director of OMHA, the Managing ALJ from each field office, and a sample of ALJ teams.[26]

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[21] We analyzed DMEPOS appeals separately from other Part B appeals throughout the report.

[22] To identify unique appellants, we took into account appellant information, such as name and Medicare identifier. In MAS, the Medicare identifiers include National Provider Identifiers and Health Insurance Claim Numbers, among others. Additionally, for appellants who were providers, we linked Medicare identifiers to information in CMS's Provider Enrollment, Chain, and Ownership System to determine which providers were part of a chain. We considered all providers that had the same Medicare identifier or that were part of the same chain to be unique appellants.

[23] Under certain circumstances, ALJs may dismiss appeals or remand them to the prior level; appellants may also escalate appeals to the next level if ALJs do not make timely decisions. See 42 CFR §§ 405.1034, 405.1052, and 405.1104.

[24] For this analysis, of the 72 ALJs, we included the 66 who decided at least 50 appeals as fully favorable, partially favorable, or unfavorable during FY 2010. These ALJs accounted for 99 percent of all appeals.

[25] To determine each ALJ's expected rate, we first calculated the fully favorable rate among all ALJs for each Medicare program area; next, we multiplied these rates by the percentage of appeals that the ALJ had in that program area and summed the results.

[26] OMHA's central office and one of its field offices are located in Arlington, Virginia. The other three field offices are in Miami, Florida; Cleveland, Ohio; and Irvine, California. At the time of the interviews, the Virginia field office had 4 ALJ teams and the other three had 13, 21, and 18 ALJ teams, respectively. For the purposes of this report, we refer to all respondents as ALJ staff.

We randomly selected 20 percent of the ALJ teams from each field office, for a total of 12 ALJ teams. The teams were each made up of an ALJ, an attorney, and other staff. We interviewed the ALJ and the attorney from each team. Our questions focused on ALJs' approaches to decisionmaking, including their application of Medicare policies and their acceptance of new evidence, and on their experience with CMS participation in appeals. We conducted these interviews in December 2010 and January 2011.

Structured Interviews With QIC and CMS Staff

We conducted structured interviews with key staff from the three CMS divisions that oversee the contractors that administer the first two levels of appeal, as well as other contractors that participate in ALJ appeals.[27] We also conducted structured interviews with key staff from each of the five QICs and the Administrative QIC, which provides support to the QICs.[28] Our questions focused on the QICs' and other contractors' experience participating in ALJ appeals and on the QICs' approaches to decisionmaking. We conducted these interviews in August and September 2011.

Review of Documentation

In the fall of 2010, we requested and reviewed written policies, procedures, and training materials from OMHA and CMS. We used these documents primarily to validate the information from our interviews.

CMS Participation Data

We obtained data from CMS regarding its contractors' participation in ALJ appeals that were decided in FY 2010.[29] For each appeal, CMS indicated which contractor participated, whether the contractor was a participant or a party, and whether it submitted a position paper or testified at the ALJ hearing. We merged these data with the MAS data.

We then calculated the percentage of all ALJ appeals in which CMS participated and assessed how the rate of participation varied by Medicare program area and by type of contractor. We also determined the extent to which CMS was a participant versus a party and the extent to which it submitted position papers versus testified at ALJ hearings. Lastly, we compared the ALJ favorable rates when CMS participated to when it did not participate.

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[27] These other contractors include the Zone Program Integrity Contractors, Program Safeguard Contractors, and Recovery Audit Contractors, all of which take steps to recoup inappropriate Medicare payments.

[28] For the purposes of this report, we refer to CMS and contractor respondents as CMS staff.

[29] These data were limited to Medicare Part A, Part B, and DMEPOS appeals. CMS does not participate in Parts C and D appeals, which typically involve disputes between appellants and their private plans.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Providers filed 85 percent of the appeals decided by ALJs in FY 2010

Providers filed 85 percent of the 40,682 appeals that ALJs decided in FY 2010. These providers included physicians, suppliers, and hospitals, among others. As shown in Table 1, beneficiaries filed 11 percent of the appeals, while State Medicaid agencies filed 3 percent. State Medicaid agencies may appeal when there is a question of whether Medicare, rather than Medicaid, should pay for the services or items received by a dually eligible beneficiary.

Table 1: Percentage of ALJ Appeals by Appellant Type, FY 2010

Type of Appellant	Number of Appellants	Number of Appeals	Percentage of Appeals
Provider	6,102	34,542	85%
Beneficiary	4,429	4,631	11%
State Medicaid Agency	5	1,361	3%
Unknown	120	148	<1%
Total	**10,656**	**40,682**	**100%**

Source: OIG analysis of MAS data, 2012.

Providers, beneficiaries, and State Medicaid agencies tended to file different types of appeals. Providers were more likely than other appellant types to file Part B and DMEPOS appeals, while beneficiaries were more likely to file Parts C and D appeals. State Medicaid agencies were more likely than other appellant types to file Part A appeals, especially home health, hospice, and skilled nursing facility appeals. For example, 90 percent of State Medicaid agency appeals were Part A appeals, while only 40 percent of provider appeals and 16 percent of beneficiary appeals were Part A appeals. See Appendix A for more information on appeals by appellant type.

A small number of providers accounted for nearly one-third of all appeals

Certain providers filed appeals much more frequently than others. On average, providers filed six appeals each. However, 96 providers were frequent filers that filed at least 50 appeals each, with 1 provider filing 1,046 appeals. While these providers represented 2 percent of all providers, they accounted for nearly one-third of all ALJ appeals in FY 2010. These providers were twice as likely as other providers to file DMEPOS appeals. No beneficiaries were frequent filers. However, 4 State Medicaid agencies filed at least 50 appeals each; 2 of these filed more than 500 appeals each.

Many ALJ staff raised concerns about the frequent filers. Several staff noted that some of these appellants appeal every payment denial. A few staff said that these appellants have an incentive to appeal because the cost is minimal and a favorable decision is likely.

For 56 percent of appeals, ALJs reversed prior-level decisions and decided fully in favor of appellants

ALJs may decide appeals in several ways: fully favorable to appellants, partially favorable to appellants, or unfavorable to appellants.[30] As shown in Table 2, ALJs reversed prior-level decisions by QICs and decided fully in favor of appellants in 56 percent of appeals in FY 2010. In contrast, QICs decided fully in favor of appellants in 20 percent of appeals in FY 2010.

Table 2: Percentage of ALJ Appeals by Decision, FY 2010

Appeal Decision	Percentage of Appeals
Fully favorable to the appellant	56%
Partially favorable to the appellant	6%
Unfavorable to the appellant	24%
Dismissed, remanded, or escalated	14%
Total	**100%**

Source: OIG analysis of MAS data, 2012.

The ALJ fully favorable rate varied substantially across Medicare program areas. As shown in Table 3, the fully favorable rate was the highest for Part A hospital appeals at 72 percent, while the rates were the lowest for Parts C and D appeals at 18 and 19 percent, respectively. Several ALJ staff noted that an ALJ typically has less discretion when deciding Parts C and D appeals because the beneficiary has agreed to a contract with a private plan that covers or does not cover the specific service or drug.

[30] Under certain circumstances, appeals may be dismissed, remanded to the prior level, or escalated to the next level.

Table 3: Percentage of ALJ Appeals That Were Fully Favorable to Appellants, by Medicare Program Area, FY 2010

Medicare Program Area	Percentage Fully Favorable to Appellants
Part A	**62%**
Hospitals	72%
Home Health/Hospice Agencies	62%
Other Part A	61%
Skilled Nursing Facilities	51%
Part B	**59%**
Transportation	67%
Diagnostic Testing	63%
Practitioner Services	60%
Other Part B	48%
DMEPOS	**53%**
Other*	**26%**
Part D	**19%**
Part C	**18%**

Source: OIG analysis of MAS data, 2012.

* This category includes appeals about beneficiary premiums and entitlement to Medicare.

The fully favorable rate also varied substantially by appellant type. For providers, it was 61 percent. In contrast, the fully favorable rate was 28 and 22 percent for beneficiaries and State Medicaid agencies, respectively. The rate was lower for beneficiaries than for providers, partly because the majority of beneficiary appeals dealt with Parts C and D, while providers rarely filed such appeals. Overall, the fully favorable rate for providers who were frequent filers differed only slightly from the rate for other providers. See Appendix B for more information about the fully favorable rates for each appellant type, as well as for providers that were and were not frequent filers.

Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors

ALJs differed from QICs in their interpretation of Medicare policies, in their degree of specialization, and in their use of clinical experts. These differences contributed to different decisions at the ALJ and QIC levels.

ALJs tended to interpret Medicare policies less strictly than QICs

Most ALJ and QIC staff agreed that reasonable people can interpret Medicare policies differently, and several staff emphasized that some policies need to be flexible to cover a wide range of beneficiary circumstances. At the same time, both ALJ and QIC staff indicated that ALJs tended to interpret Medicare policies

less strictly than QICs. Most ALJ staff noted that ALJs often decided in favor of appellants when the intent, but not the letter, of a Medicare policy was met. In contrast, most QICs noted that they try to follow Medicare policy strictly. One QIC added that it approaches appeals expecting to uphold prior-level decisions unless the evidence to reverse is compelling.

ALJ and QIC staff offered several examples to illustrate their differences in interpreting Medicare policies. In one example, QICs denied home health services because beneficiaries did not meet the requirement to be homebound; then ALJs determined that the home health services were reasonable and necessary without focusing on the homebound requirement. In another example, QICs denied payments because beneficiaries met only 9 out of 10 criteria in the Local Coverage Determination, but ALJs found that the beneficiaries met the broader intent of the policy and reversed the decision.

In addition, ALJ and QIC staff commonly noted that some Medicare policies are unclear. Several staff cited examples of policies with vague definitions, such as coverage for beneficiaries who have "unique characteristics" or are "declining." Many ALJ staff emphasized the need to write policies more narrowly or more clearly, noting that unclear policies lead to more fully favorable decisions and to more variation among ALJs.

ALJs and QICs differed in the degree to which they specialized in Medicare program areas and in their use of clinical experts

Each of the QICs specializes in a Medicare program area: two QICs are responsible for Part A appeals, two for Part B, and one for DMEPOS. In contrast, ALJs typically decide appeals involving all Medicare program areas because their appeals are usually randomly assigned.[31] Several ALJ staff noted that increased specialization would make the appeals system more efficient. As one ALJ respondent noted, "In a month, I will have 10 Part A, 10 Part B, 3 Part D … [going] back and forth between different regulations … it's hard."

Additionally, ALJs and QICs used clinical experts to different degrees. QICs have medical directors and clinicians on staff to review decisions. In contrast, ALJs do not have medical directors and clinicians on staff. Several ALJ staff said ALJs tended to rely on testimony and other evidence from treating physicians. For example, one ALJ staff member said, "[The ALJ] will listen to the treating physician and will give deference to the physician's opinion."

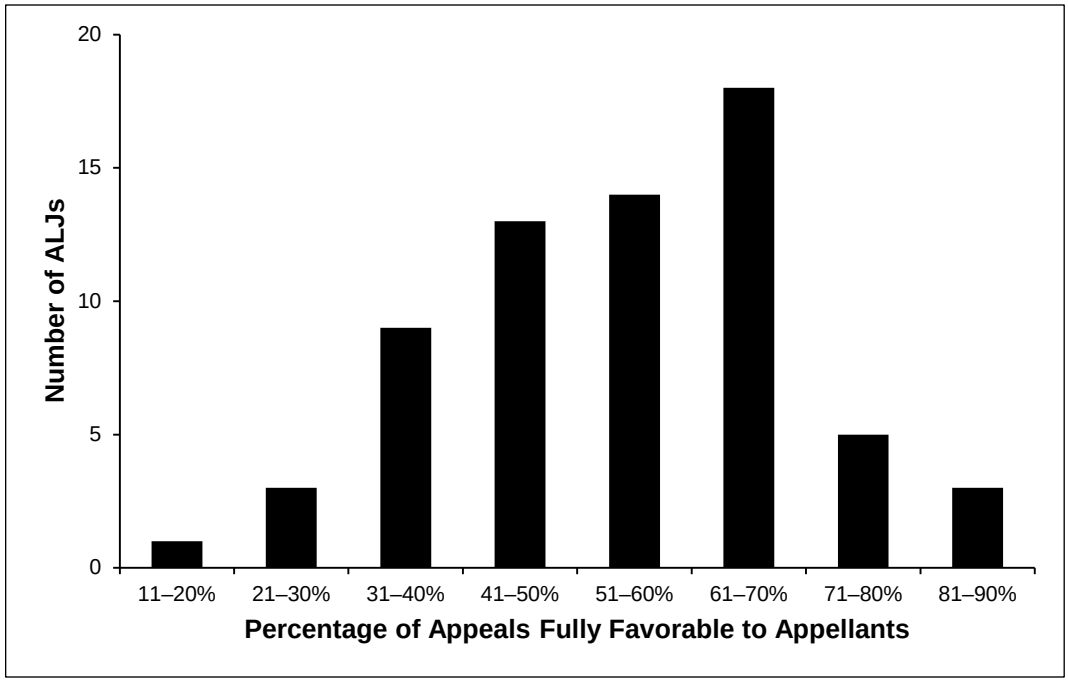
The favorable rate varied widely by ALJ

Some ALJs were much more likely than others to make decisions that were fully favorable to appellants. Among the 66 ALJs, the fully favorable rate ranged from

[31] ALJ appeals must be assigned "in rotation so far as practicable." See 5 U.S.C. § 3105.

18 to 85 percent.[32] As shown in Figure 1, while about two-thirds of ALJs had fully favorable rates between 41 and 70 percent, 8 ALJs had fully favorable rates higher than 70 percent and 13 had fully favorable rates at or below 40 percent. Very little of this variation was associated with some ALJs' deciding more appeals in certain Medicare program areas than other ALJs. See Appendix C.

Figure 1: Number of ALJs by the Percentage of Appeals That Were Fully Favorable to Appellants, FY 2010



Source: OIG analysis of MAS data, 2012.

Moreover, frequent filers often received fully favorable decisions at very different rates from different ALJs. For example, a supplier with nearly 600 appeals received fully favorable decisions at rates ranging from 7 to 100 percent from the 17 ALJs who decided at least 10 of the supplier's appeals.

According to many ALJ staff, different philosophies among ALJs contribute to the variation in fully favorable rates. They said that given the same facts and the same applicable Medicare policy, some ALJs would make decisions that are favorable to appellants, while others would not. One ALJ concluded, "Some [ALJs] pay, some deny." Another ALJ stated, "I go towards protecting the Medicare Trust Fund[s]."

[32] The analysis for this finding was limited to ALJs who decided at least 50 appeals as fully favorable, partially favorable, or unfavorable during FY 2010.

ALJs also varied in their use of on-the-record reviews. An ALJ may make a decision after an on-the-record review of the case file, instead of after a hearing, if the appellant waives the right to a hearing or if the evidence supports a fully favorable decision for the appellant. Among all ALJs, the percentage of appeals decided after on-the-record reviews ranged from less than 1 to 65 percent.

CMS participated in 10 percent of ALJ appeals; these appeals were less likely to be decided fully in favor of appellants

Overall, CMS participated in 10 percent of the appeals that ALJs decided in FY 2010.[33] Participation varied substantially across Medicare program areas, with CMS participating in 18 percent of DMEPOS appeals, 9 percent of Part A appeals, and 5 percent of Part B appeals. In 61 percent of the appeals in which CMS participated, it provided testimony during hearings. In the remaining 39 percent of appeals, CMS submitted position papers to the ALJs. CMS rarely chose to be a party, which would have allowed it to submit evidence, call or cross-examine witnesses, or appeal to the next level.

When CMS participated, ALJs were less likely to decide fully in favor of appellants. Overall, 44 percent of ALJ decisions were fully favorable to appellants when CMS participated. In contrast, 60 percent of ALJ decisions were fully favorable when CMS did not participate. As shown in Table 4, this difference was greatest for DMEPOS appeals.

Table 4: Fully Favorable Rates When CMS Participated and When CMS Did Not Participate, by Medicare Program Area, FY 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants		Percentage Point Difference*
	When CMS Participated	When CMS Did Not Participate	
Part A	59%	62%	4
Part B	48%	59%	12
DMEPOS	30%	58%	28
All Appeals	**44%**	**60%**	**16**

Source: OIG analysis of MAS data and CMS participation data, 2012.

* Rows do not subtract to percentage point differences because of rounding.

CMS and ALJ staff noted several benefits of CMS participation. Most CMS staff cited an improved relationship between the two agencies, and many ALJ staff

[33] The analysis for this finding was limited to Part A, Part B, and DMEPOS appeals. CMS does not participate in Parts C and D appeals, which typically involve disputes between appellants and their private plans.

noted that CMS often provided needed information. Most CMS staff further noted that their participation in ALJ appeals has taught them to include more specific information in their decisions and position papers to make them more useful to ALJs.

Citing these benefits, nearly all CMS staff reported plans to increase participation in ALJ appeals, especially by the contractors that originally denied the claims or recouped the claim payments. A few staff noted that these contractors are often in the best position to defend their decisions. In FY 2010, only one of these contractors participated regularly, with QICs accounting for nearly all of the remaining participation.[34] CMS staff also reported plans to become a party, rather than a participant, more often, stating that this will allow the agency to better present its position.

Staff raised concerns about the acceptance of new evidence and the organization of case files

Most CMS and ALJ staff noted that the requirements for accepting new evidence at the ALJ level are open to wide interpretation. Starting in 2005, ALJs may accept new evidence only if they determine that appellants had good cause for waiting until the appeals reached the ALJ level to submit it. Most ALJ staff said that they typically accepted new evidence when submitted. As one ALJ explained, an ALJ's role "is to make a determined effort to find out all of the relevant information to make the best determination…. Maybe I let that color my determination of letting in new evidence."

Nearly all CMS staff reported that the ALJs' acceptance of new evidence reduced the efficiency of the appeals system. Most of them noted that appellants are required, and have many opportunities, to submit evidence prior to the ALJ level. According to one CMS staff member, when ALJs accept new evidence without good cause, it "eliminates the value of the two previous levels of appeal."

Nearly all CMS and ALJ staff also identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level. Staff noted that these differences created inefficiencies in the appeals process. Most ALJ staff reported that incomplete or disorganized case files caused them to spend time requesting information from QICs or appellants, remanding appeals back to QICs, or reorganizing case files. Many ALJ and CMS staff noted that the two agencies need to reach an agreement regarding how QICs should organize the case files before sending them to the ALJ level.

[34] CMS funded a demonstration project to increase participation by one of the DMEPOS contractors that make the initial decisions to pay or deny claims.

In addition, problems arise because the QICs' case files are almost entirely electronic, while ALJs accept only paper case files. The QICs convert the electronic case files to paper format before sending them to the ALJs; most staff noted that this process is resource intensive and prone to error. In a February 2011 report to Congress, the Chief ALJ acknowledged that her agency had "a critical need to transform its case file process from paper to a fully electronic environment."[35]

ALJ staff handled suspicions of fraud inconsistently

When deciding an appeal, ALJ staff may come across evidence that suggests an appellant engaged in Medicare fraud. For example, evidence may suggest that the Medicare services were not furnished or were not furnished as billed. Nearly all ALJ staff reported having suspected appellants of Medicare fraud; however, they were inconsistent in how they handled their suspicions. In addition, the agency does not have written policies about how ALJ staff should handle suspected fraud.

Notably, ALJ staff differed in the extent to which they referred suspected fraud to their supervisors or to law enforcement. While many staff had made at least one fraud referral, many others did not make referrals based on their suspicions. Several of those who did not refer stated that the evidence of fraud was limited and a referral would not have been appropriate. Several others, however, indicated that making fraud referrals is not part of their job. For example, one staff member said, "[I] never referred and don't want to refer anything … [it is] not our business here;" another said "there is an unspoken rule not to report [fraud]."

When deciding an appeal, ALJ staff also differed in whether they sought additional information when they suspected fraud. A few staff reported that they sought additional information by reviewing licensing databases, searching the Internet, or calling investigators. Several staff also were in favor of more communication between law enforcement and ALJs regarding fraud investigations. In contrast, other staff were opposed to having any additional information when deciding an appeal.

ALJ staff also differed in how they made decisions when they suspected fraud. Several ALJs explained that they decide against appellants if the evidence lacks credibility and they suspect fraud. For example, one ALJ reported that he denied a group of claims because all the medical records looked suspiciously similar. In contrast, a few ALJs suggested that they assume the evidence is factual and do not assess whether it may have been falsified.

Further, a few ALJ and CMS staff noted that having an appellant simultaneously in the appeals system and under investigation for fraud presented challenges. In

[35] OMHA, FY 2012 Justification of Estimates for Appropriations Committees, p. 4.

particular, CMS expressed concern that an appellant may manipulate the appeals system to influence the fraud investigation. For example, appellants may selectively appeal claims to obtain favorable ALJ decisions. Staff reported that favorable ALJ decisions may compromise law enforcement's ability to get a conviction from a fraud investigation.

CONCLUSION AND RECOMMENDATIONS

ALJs decide tens of thousands of appeals each year. Because these decisions are critical to providers and beneficiaries and affect the Medicare program as a whole, it is imperative that the appeals process be efficient, effective, and fair.

Our review found that the vast majority of ALJ appeals in FY 2010 were filed by providers, with a small number of providers accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed prior-level decisions by QICs and decided fully in favor of appellants. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. These differences may provide appellants an incentive to appeal to the ALJ level, where they are likely to receive favorable decisions.

Additionally, the favorable rate varied widely by ALJ. Further, when CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. In addition, ALJ and CMS staff raised concerns that the acceptance of new evidence and the organization of case files reduced the efficiency of the appeals system. Lastly, ALJ staff handled suspicions of fraud inconsistently.

Our findings highlight a number of inconsistencies and inefficiencies in the Medicare appeals process. Together, they demonstrate that OMHA and CMS must take action to improve the appeals system, while maintaining ALJs' independence.

Therefore, we recommend that OMHA and CMS:

Develop and Provide Coordinated Training on Medicare Policies to ALJs and QICs

OMHA and CMS should work together to develop and provide training on Medicare policies to ALJ and QIC staff. By coordinating training, OMHA and CMS will help ensure that knowledge of Medicare policies is consistent at the second and third levels of appeal. OMHA and CMS should provide training at least annually and focus on policies that tend to be interpreted differently by ALJs and QICs or among ALJs. For example, one area of focus should be Part A hospital appeals in which ALJs reversed prior-level decisions for nearly three-quarters of appeals. The agencies should identify training topics by analyzing appeals data and surveying staff.

Identify and Clarify Medicare Policies That Are Unclear and Interpreted Differently

Unclear policies can lead to inconsistencies between ALJs and QICs and among ALJs. At least annually, CMS and OMHA should identify policies that are unclear and interpreted differently by soliciting input from CMS contractors and ALJ staff and by analyzing appeals data. The agencies should focus on policies with vague definitions, such as beneficiaries who are "declining," and on program

areas with particularly high favorable rates, such as Medicare Part A. CMS should then work to develop or clarify these policies, as needed.

Standardize Case Files and Make Them Electronic

To improve the efficiency of the appeals process, OMHA and CMS should make case files more consistent across the various levels of appeal. Finalizing and enforcing a Memorandum of Understanding should be a first step toward standardizing the content and organization of case files. As well as specifying how the documents in the case file should be organized, the memorandum should define a method, such as a checklist, for easily identifying which documents are in the case file. OMHA and CMS should train staff on the memorandum requirements.

In addition, OMHA should accelerate its Electronic Records Initiative to transition from paper to electronic files. OMHA and CMS must coordinate this effort closely and should take other measures in the interim to reduce formatting differences in case files. The agencies may require additional funding to complete the transition to electronic case files.

Revise Regulations To Provide More Guidance to ALJs Regarding the Acceptance of New Evidence

Current regulations regarding the acceptance of new evidence provide little guidance and only one example of good cause—when the QIC raises a new issue not discussed at the first level of appeal. OMHA and CMS should revise these regulations to include additional examples as well as factors for ALJs to consider when determining good cause. In particular, the regulations should specify that ALJs consider whether the appellant could have obtained the evidence earlier.

Improve the Handling of Appeals From Appellants Who Are Also Under Fraud Investigation and Seek Statutory Authority To Postpone These Appeals When Necessary

When Medicare providers are simultaneously in the appeals system and under investigation for fraud, both the appeals process and the investigations may be compromised. OMHA and CMS should improve how these cases are handled. CMS should work with its contractors and law enforcement to identify and monitor the appeals of providers that are under investigation. This information should be used to inform decisions about administrative and law enforcement actions and about whether CMS should participate at the ALJ level of appeal.

Additionally, OMHA and CMS should seek statutory authority to postpone appeals at the levels they administer. The agencies should make decisions to postpone appeals only after receiving a request from law enforcement and should work with law enforcement to define the circumstances under which appeals may be postponed. Postponement decisions should be made by OMHA and CMS staff who are not directly responsible for deciding appeals.

We recommend that OMHA:

Seek Statutory Authority To Establish a Filing Fee

Given the concerns raised about appellants who filed frequently, OMHA should seek statutory authority to implement a modest filing fee. Such a fee would only nominally affect the average appellant, but would encourage frequent filers to more carefully assess their appeals before filing. The fee should not apply to beneficiaries. OMHA should consider various options for making the fee effective and fair, such as scaling the fee to the dollar amount at issue.

Implement a Quality Assurance Process To Review ALJ Decisions

The range of fully favorable rates among ALJs raises concerns about whether all ALJs are applying Medicare policies in accordance with regulations. Medicare regulations state that ALJs are bound by Medicare laws, regulations, and National Coverage Determinations and must give substantial deference to Local Coverage Determinations and CMS program guidance. OMHA should implement a quality assurance process to review ALJ decisions. OMHA could, for example, review a sample of ALJ decisions and, when needed, provide ALJs with additional training. OMHA may want to focus its efforts on certain types of appeals, such as those concerned with policies that tend to be interpreted differently among ALJs. OMHA should also assess ALJs' use of on-the-record reviews to make decisions.

Determine Whether Specialization Among ALJs Would Improve Efficiency

OMHA should determine whether specialization among ALJs would improve the efficiency of the appeals process. Any specialization would need to be consistent with the statutory requirement to randomly assign appeals. If OMHA decides to implement specialization, it should develop policies and procedures describing the manner and extent to which ALJs will specialize.

Develop Policies To Handle Suspicions of Fraud Appropriately and Consistently and Train Staff Accordingly

OMHA should develop policies and provide training to ALJ staff regarding how to handle suspicions of fraud. These policies and training should be developed in collaboration with CMS and OIG and should inform staff about when and how to refer suspicions of fraud. The policies and training should also instruct staff to base decisions only on evidence in the case files and hearing testimony, as required by Federal regulation, and to consider the credibility of the evidence when making decisions. OMHA should work with CMS and OIG periodically to keep informed about emerging fraud trends.

We recommend that CMS:

Continue To Increase CMS Participation in ALJ Appeals

Given the benefits cited by both agencies, CMS should continue to increase its participation in ALJ appeals. Building upon its current efforts, CMS should make

strategic decisions about which contractors are in the best position to represent CMS and which appeals most warrant CMS participation, such as Part A hospital appeals or those from frequent filers. CMS should establish participation guidelines and incentives for each type of contractor and should track the results of their participation. The guidelines should indicate the circumstances in which a contractor should consider becoming a party, rather than a participant.

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMHA and CMS concurred fully or in part with all 10 of our recommendations. With regard to the first recommendation, OMHA stated that it instituted, and CMS participated in, an annual symposium that offers ALJs training on a wide range of Medicare policies and emerging issues. CMS added that it has invited OMHA to participate in its annual conference for contractor medical directors and that it will continue working with OMHA to identify new opportunities for collaboration.

With regard to the second recommendation, OMHA noted that while it is beyond the scope of its mission to participate in Medicare policy development, it supports efforts to clarify unclear policies and increased communication with CMS when decisional trends reveal differing policy interpretations. CMS noted the value of tracking appeals to determine which Medicare policies are most often at issue and stated that in some instances, it might be beneficial to clarify a particular policy.

With regard to the third recommendation, OMHA stated that it is working with CMS to develop a Memorandum of Understanding regarding standardizing case files and to determine whether MAS can accommodate the electronic folder or whether a new operating system must be developed. CMS added that it will continue to discuss with OMHA options to fully develop an electronic system.

With regard to the fourth recommendation, OMHA stated that it will review regulations regarding acceptance of new evidence and will develop guidance and provide training to address ALJs' concerns raised in the report. CMS added that it will explore options for providing additional guidance regarding accepting new evidence at the ALJ level.

With regard to the fifth recommendation, OMHA stated that it did not concur with staff's issuing determinations regarding postponement of ALJ decisions because of due process concerns. CMS raised the same concerns and further noted that postponing appeals could compromise fraud investigations. At the same time, OMHA stated that it supports CMS's developing a mechanism to limit appeals to the ALJ level, and CMS proposed discussing concerns with OMHA to determine the best approach for handling these appeals. In response, we recognize the seriousness of the due process and other concerns and emphasize that postponement should be considered only after weighing these concerns together with the potential impact of fraudulent activities on beneficiaries and the Medicare Trust Funds. We further emphasize that the agencies should make decisions to postpone appeals only after receiving a request from law enforcement and that these postponement decisions should not be made by ALJs or others who are directly responsible for deciding appeals.

With regard to the sixth through ninth recommendations, OMHA stated that it will evaluate whether or not filing fee authority is appropriate and, if so, seek authority to collect such fees. It further noted that it has instituted a Quality Assurance Program based upon peer review of ALJ decisions. OMHA also stated that although it is not convinced that ALJ specialization would improve case processing, it will conduct further evaluation. Lastly, it stated that it has conducted training and continues to develop policies with respect to handling suspicions of fraud.

With regard to the tenth recommendation, CMS stated that it plans to increase participation in ALJ appeals by the agency's contractors. It will also enhance participation guidelines for contractors and monitor the results of participation to determine the most effective and efficient use of the resources currently available.

The full text of OMHA's comments is provided in Appendix D, and the full text of CMS's comments is provided in Appendix E.

APPENDIX A

Administrative Law Judge Appeals Filed by Each Type of Appellant, Fiscal Year 2010

Medicare Program Area	Percentage of Provider Appeals	Percentage of Beneficiary Appeals	Percentage of State Medicaid Agency Appeals
Part A	40%	16%	90%
Hospitals	9%	4%	<1%
Home Health/ Hospice Agencies	13%	1%	48%
Other Part A	14%	8%	3%
Skilled Nursing Facilities	4%	4%	39%
Part B	34%	16%	<1%
Transportation	5%	7%	<1%
Diagnostic Testing	7%	1%	0%
Practitioner Services	13%	3%	0%
Other Part B	9%	5%	<1%
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	25%	5%	0%
Part C	1%	47%	10%
Part D	<1%	8%	0%
Other*	<1%	8%	0%
Total**	**100%**	**100%**	**100%**

Source: Office of Inspector General analysis of Medicare Appeals System data, 2012.

* This category includes appeals about beneficiary premiums and entitlement to Medicare.

** Total may not sum to 100 percent because of rounding.

APPENDIX B

Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants, Fiscal Year 2010

Table B-1: Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants by Type of Appellant, Fiscal Year 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants**		
	Providers	Beneficiaries	State Medicaid Agencies
Part A	67%	36%	24%
Part B	59%	46%	n/a
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	53%	40%	n/a
Part C	15%	19%	7%
Part D	15%	20%	n/a
Other*	n/a	26%	n/a
Total	**61%**	**28%**	**22%**

Source: Office of Inspector General (OIG) analysis of Medicare Appeals System (MAS) data, 2012.

***** This category includes appeals about beneficiary premiums and entitlement to Medicare.

****** The percentage of appeals with fully favorable decisions was calculated only if there were 50 or more appeals for that Medicare program area.

Table B-2: Percentage of Administrative Law Judge Appeals That Were Fully Favorable to Appellants by Frequent Filer Status, Fiscal Year 2010

Medicare Program Area	Percentage of Appeals Fully Favorable to Appellants**	
	Providers Who Were Frequent Filers***	Providers Who Were Not Frequent Filers
Part A	67%	67%
Part B	70%	54%
DMEPOS	50%	58%
Part C	n/a	15%
Part D	n/a	15%
Other*	n/a	n/a
Total	**61%**	**60%**

Source: OIG analysis of MAS data, 2012.

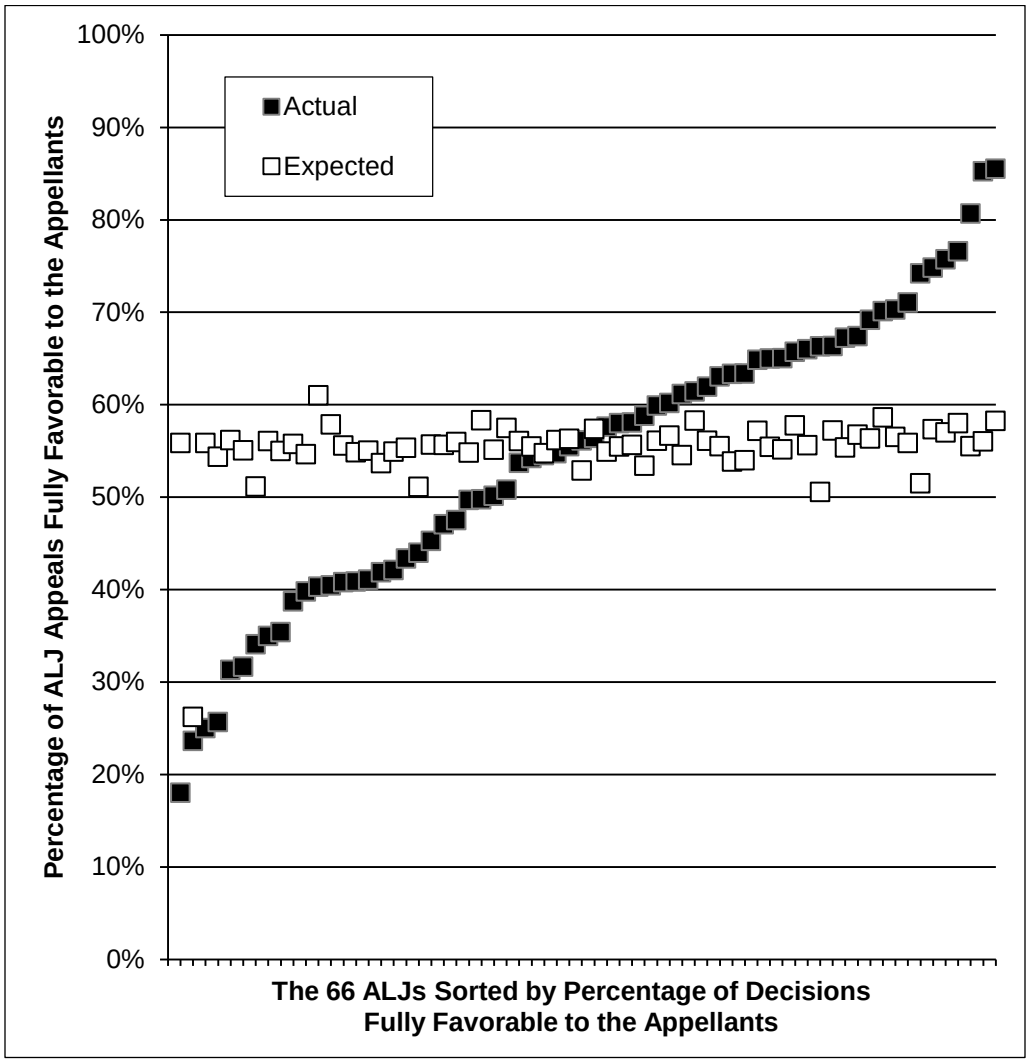
***** This category includes appeals about beneficiary premiums and entitlement to Medicare.

** The percentage of appeals with fully favorable decisions was calculated only if there were 50 or more appeals for that Medicare program area.

*** A frequent filer is an appellant that had 50 or more appeals decided in fiscal year 2010.

APPENDIX C

Actual Fully Favorable Rates Compared to Expected Fully Favorable Rates by Administrative Law Judge,* Fiscal Year 2010



Source: Office of Inspector General analysis of Medicare Appeals System data, 2012.

Note: To calculate each ALJ's expected rate, we first determined the fully favorable rate among all ALJs for each Medicare program area; next, we multiplied these rates by the proportion of appeals the ALJ had in that program area and summed the results.

*ALJ.

APPENDIX D

Office of Medicare Hearings and Appeals Comments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary

Office of Medicare Hearings and Appeals
Office of the Chief Judge
1700 North Moore Street, Suite 1800
Arlington, VA 22209
(703) 235-0635 Main Line
(703) 235-0700 Facsimile

MEMORANDUM

Date: September 14, 2012

To: Daniel R. Levinson
Inspector General

/S/

From: Nancy J Griswold
Chief Administrative Law Judge

Subject: Office of Inspector General Draft Report: *Improvements are needed at The Administrative Law Judge Level of Medicare Appeals,* OEI-02-10-00340

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on Medicare appeals at the Administrative Law Judge (ALJ) level. The Office of Medicare Hearings and Appeals (OMHA) appreciates the thoroughness of the report and concurs with many of the suggested recommendations which are based on the evaluation of ALJ appeals during fiscal year 2010.

We are happy to report that a number of recommendations are already being addressed through OMHA's continuing efforts to review and improve operations. However, with respect to a few recommendations, we believe that more evaluation is necessary. Our response to the recommendations is set forth below.

RECOMMENDATION: *Develop and Provide Coordinated Training on Medicare Policies to ALJs and QICs*

RESPONSE: CONCUR

Beginning in fiscal year 2010, OMHA instituted an annual Judicial Education Symposium (JES) for all OMHA ALJs. JES is conducted in three phases throughout the calendar year and offers training on a wide range of Medicare policies and emerging OMHA issues. The symposium presenters include Centers for Medicare and Medicaid Services (CMS) subject matter experts, Medicare Appeals Council (MAC) judges and OMHA's most experienced ALJs. OMHA seeks input from ALJs and CMS in identifying topics for presentation based on new policies or

emerging trends. For the 2012 JES series, nine hours are being devoted to CMS policy issues. OMHA and CMS conduct bi-weekly conference calls to discuss policy and processing matters.

In addition to the JES, OMHA instituted a Substantive Law Training program in fiscal year 2011. The Substantive Law Training program provides standarized high-quality training to recently hired attorneys and ALJs on Medicare law and policy. A cadre composed of experienced OMHA Attorney-Advisors and ALJs developed the written and oral presentations. OMHA has also developed specialized training for paralegals and is in the process of developing a comprehensive legal assistant training program. Finally, OMHA is working with CMS to provide quarterly policy updates to adjudicators and staff.

RECOMMENDATION: *Identify and Clarify Medicare Policies That are Unclear and Interpreted Differently*

RESPONSE: CONCUR WITH COMMENTS

CMS is charged by the Secretary with administering the Medicare program; OMHA's mission is to process Medicare appeals within the existing policy framework established by CMS on behalf of the Secretary. It is beyond the scope of OMHA's mission to participate in Medicare policy development, including policy clarification. Policy clarification is, and should remain, the responsibility of CMS as it is the administrator of the Medicare program. Nevertheless, OMHA supports all efforts to improve the Medicare program, including clarification of unclear policies and increased communication between OMHA and CMS when decisional trends reveal differing policy interpretations. OMHA has opened the dialogue with CMS.

Although clarification of Medicare policies is not within OMHA's program mission, OMHA wishes to point out that clarification of procedural policies governing the hearing process is within OMHA's responsibilities. This position is consistent with our response to the fourth recommendations regarding the admission of new evidence.

RECOMMENDATION: *Standardize Case Files and Make Them Electronic*

RESPONSE: CONCUR

Regarding standardizing case files, OMHA is working with CMS to develop a Memorandum of Understanding (MOU) with respect to the standardized order in which the Qualified Independent Contractor (QIC) furnishes Medicare Part B case files to OMHA. OMHA will also look to update its current Medicare Part A MOU with CMS and the QICs, consistent with the Medicare Part B MOU regarding case file standardization and organization.

We also agree that an electronic case processing system would increase efficiency within OMHA. We have developed requirements to be used in development of an electronic case processing system. OMHA and CMS are currently working cooperatively to determine whether the existing platform, the Medicare Appeals System (MAS), can accommodate the electronic folder or whether a new operating system must be developed. As the OIG noted, the development and institution of an electronic case processing system is dependent on funding.

RECOMMENDATION: *Revise Regulations to Provide More Guidance to ALJs regarding the Acceptance of New Evidence*

RESPONSE: CONCUR WITH COMMENTS

OMHA has identified several regulations which it is currently evaluating for future changes. OMHA will review regulation(s) regarding acceptance of new evidence and determine whether any future revisions are warranted. Additionally, OMHA will develop policy guidance and provide training to address the concerns raised by ALJs interviewed for this report.

RECOMMENDATION: *Improve the Handling of Appeals that are also under Fraud Investigation and Seek Statutory Authority to Postpone These Appeals when Necessary.*

RESPONSE: CONCUR IN PART, WITH COMMENTS

OMHA agrees there is a need for additional internal policy guidance with respect to the handling of referrals for investigation when an ALJ, or ALJ team member, believes a file contains evidence of fraud. OMHA will formalize its guidance in an upcoming Chief Judge Bulletin.

The OIG suggests OMHA and CMS work with law enforcement to define the circumstances under which appeals can be postponed. OMHA does not concur with the OIG's recommendation that OMHA and CMS staff issue determinations regarding postponement of ALJ decisions when appellants are under investigation for fraud. Suspending hearings, and possible payments, for appellants who have not been found in an adjudicatory proceeding to be in violation of fraud statutes raises due process concerns.

Moreover, OMHA is also concerned that the OIG's recommendation may be inconsistent with the Federal Administrative Procedure Act (APA) requirement that ALJs decide cases based on evidence in the record and that ALJs not be subject to the direction of an employee or agent engaged in the investigative function of an agency. *See,* 5 U.S.C. § 554. Currently, the only legal authority that would allow OMHA to suspend appeals simultaneously being investigated by law enforcement authorities is a stay issued by a Federal court.

Generally, ALJs have no knowledge of criminal investigations involving appellants at the time cases are received. In fact, such cases have already passed through two levels of appeals before reaching OMHA. OMHA supports CMS developing a mechanism to limit appeals to the ALJ level by identifying potential fraud cases before they are allowed into the appeals system. Further, an ALJ does have the option to reopen his or her decision in light of any new evidence.

RECOMMENDATION: *Seek Statutory Authority to Establish a Filing Fee*

RESPONSE: CONCUR WITH COMMENTS

OMHA will evaluate whether or not filing fee authority is appropriate for the ALJ appeals process, and if so, seek statutory authority to collect filing fees. The benefit of a filing fee requirement must be weighed against the potential financial burden imposed on beneficiaries.

RECOMMENDATION: *Implement a Quality Assurance Process to Review ALJ Decisions*

RESPONSE: CONCUR

OMHA concurs with this recommendation. OMHA has instituted a Quality Assurance Program (QAP) based upon peer review of a random sample of ALJ decisions using standard guidelines. OMHA began development of the program in 2011 and began weekly peer review of ALJ decisions in August of 2012.

RECOMMENDATION: *Determine Whether Specialization among ALJs Would Improve Efficiency*

RESPONSE: CONCUR WITH COMMENTS

OMHA is not convinced that ALJ specialization would actually improve case processing efficiency or accuracy. Further, as mentioned in the OIG's recommendation, federal law requires all ALJ appeals are assigned in a random rotation. *See* 5 U.S.C. § 3105 (2011). Notwithstanding the above, OMHA will conduct further evaluation to determine whether this recommendation would improve case processing efficiency in a manner which does not violate federal law.

RECOMMENDATION: *Develop Policies and Train Staff to Handle Suspicions of Fraud Appropriately and Consistently*

RESPONSE: CONCUR

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 with respect to handling suspicions of fraud. As stated earlier, OMHA maintains frequent contact with a designated OIG Office of Investigations contact at the national level and has made several fraud referrals.

Further, OMHA training of ALJs and Attorney-Advisors has reiterated that decisions must always be based on evidence in the case file and hearing testimony. Such decisions must also be made in accordance with existing Medicare law, regulations, and policy.

Once again, we do appreciate the opportunity to review and comment on this report. Please contact me if you have any questions regarding our comments.

APPENDIX E

Centers for Medicare & Medicaid Services Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 18 2012

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals" (OEI-02-10-00340)

Thank you for the opportunity to review and comment on the OIG draft report, "Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals." In the draft report, the OIG examined the characteristics of appeals decided by Medicare administrative law judges (ALJs) in fiscal year (FY) 2010; the differences between ALJ and prior-level decisions and differences among ALJs; and the extent to which the Centers for Medicare & Medicaid Services (CMS) participated in ALJ appeals in FY 2010. We appreciate the OIG's time and effort in reviewing our processes. Our responses to the OIG's recommendations are below.

Recommendations to CMS and the Office of Medicare Hearings and Appeals (OMHA):

OIG Recommendation

The OIG recommends CMS and OMHA develop and provide coordinated training on Medicare policies to Administrative Law Judges (ALJs) and Qualified Independent Contractors (QICs).

CMS Response

The CMS concurs with this recommendation. In 2011 and 2012, CMS staff participated in OMHA's annual Judicial Education Symposium, and conducted training on a variety of Medicare policy issues. The symposia afford ALJs and their staffs an opportunity to discuss general policy and procedural issues with CMS. This training is mutually beneficial, and we would welcome the opportunity to include the QICs in future sessions. Similarly, in recent years, CMS has invited OMHA leadership to participate in our annual Contractor Medical Director conference attended by CMS staff and staff from our Medicare Administrative Contractors (MACs), QICs, Recovery Auditors (RAs), and Zone Program Integrity Contractors (ZPICs). Like the Judicial Education Symposia, this conference provides an opportunity for our contractor staff to interact with and ask questions of OMHA staff and senior leadership about policy and procedural issues. Finally, our QICs also have access to training and educational

opportunities on Medicare policies, procedures and initiatives via monthly meetings organized by CMS' Administrative QIC (AdQIC), and monthly policy updates issued by the AdQIC to all QICs.

Going forward, CMS will continue working with OMHA and the AdQIC to identify new opportunities for collaboration on trainings for our appeals adjudicators, and where possible, provide joint training sessions for the QICs and ALJs. Additionally, CMS will continue evaluating appeals decisions to help identify policies that are being interpreted inconsistently by QICs and ALJs, and use this information to develop future appeals training programs.

OIG Recommendation

The OIG recommends CMS and OMHA identify and clarify Medicare policies that are unclear and interpreted differently.

CMS Response

The CMS concurs with this recommendation. We agree with the OIG that there is value in tracking appeals so we can evaluate the cases that are being reversed and determine which Medicare policies are most often at issue in these cases. Similarly, we agree that in some instances, as a result of reversals at higher adjudicative levels, it might be beneficial to clarify a particular Medicare policy. Currently, the AdQIC identifies and reports to CMS, on an annual basis, policies and procedures that seem to be unclear, based on appeals outcomes, and provides recommendations for revisions.

The CMS also believes that appeals outcomes at the ALJ level should be used by lower level adjudicators to evaluate their review strategies. Thus, CMS intends to look at ways to help ensure that all contractors (MACs, RAs, ZPICs, and QICs) are evaluating the outcomes of their appeals at the ALJ level and appropriately considering the applicable ALJ reversal rates in developing any future review strategies. This approach will help ensure that resources at all levels of the appeals process are being used most effectively.

OIG Recommendation

The OIG recommends CMS and OMHA standardize case files and make them electronic.

CMS Response

The CMS concurs with this recommendation and notes that together with OMHA, we have been exploring a number of process improvements, such as electronic records from the QICs, to help expedite the appeals process for both parties and adjudicators. Currently, the Medicare Appeals System (MAS) stores some electronic appeals case files, and promotes them to OMHA through the MAS. However, the MAS functionality to support manipulation of the electronic files is limited. Nevertheless, OMHA has made substantial progress in implementing the needed electronic case file functionality and is conducting a gap analysis to determine any additional steps that may be needed in order to fully implement an electronic case file system. We will

continue to discuss with OMHA options to fully develop an electronic appeals case file processing environment.

Similar efforts are also underway to implement the transfer of appeal case files electronically between the QICs and MACs. Some of the MACs have already initiated an electronic case file transfer process with the QICs. We are currently working on the requirements phase of implementing the MAS for the MACs. Implementation is dependent on funding, but our goal is to have all MACs utilizing MAS for Part A appeals by 2014. This initiative will facilitate an electronic appeals process and realize operational efficiencies by using one consolidated appeals system.

OIG Recommendation

The OIG recommends CMS and OMHA revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence.

CMS Response

The CMS concurs in part with this recommendation. As part of our on-going discussions with OMHA, CMS will explore options for providing additional guidance regarding accepting new evidence for the first time at the ALJ level, including possible revisions to the fee-for-service regulations at 42 CFR Part 405.

OIG Recommendation

The OIG recommends CMS and OMHA improve the handling of appeals that are also under fraud investigation and seek statutory authority to postpone these appeals when necessary.

CMS Response

The CMS concurs in part with this recommendation. We agree that CMS and OMHA can improve and better coordinate their processes for handling appeals that are also under fraud investigation. Also, when the same claims are part of both a fraud investigation and an administrative appeal, it may be beneficial to delay either the appeals process or the fraud investigation to avoid inconsistent decisions in two parallel proceedings involving the same facts. However, we note that suspending appeals may impact the due process rights guaranteed to appellants. Additionally, given our current policy to not suspend appeals in such cases, we believe that implementing a delay might tip-off providers about the fraud investigation. Thus, prior to undertaking the OIG's recommendation to seek statutory authority to delay appeals, we propose to first discuss our concerns with OMHA, so that we can determine the best approach for handling appeals that are also under fraud investigation, and ensure that our approach maintains the due process rights of all appellants, is not detrimental to Medicare beneficiaries and does not have the potential to compromise the resolution of a pending criminal matter.

Recommendation to CMS:

OIG Recommendation

The OIG recommends CMS continue to increase CMS participation in ALJ appeals.

CMS Response

The CMS concurs in part with this recommendation. We agree with the OIG's assessment that participation in ALJ hearings provides an opportunity for contractors to explain Medicare policies and the reason(s) for claim denials in more detail, educate adjudicators at all levels of the appeals process, and increase the ALJ uphold rate. The QICs have participated in ALJ hearings since their inception in 2005. Starting in 2009, CMS expanded contractor participation, to include one Durable Medical Equipment Medicare Administrative Contractor (DME MAC). After evaluating the results of this participation and securing additional funding, it was expanded to include all the DME MACs in 2011. In addition, pending available funding, CMS plans to continue increasing participation requirements in the MAC Statements of Work. In addition, RAs and ZPICs have also begun increasing their participation in ALJ hearings.

Going forward, to help facilitate contractor participation in ALJ hearings, CMS intends to continue developing requirements aimed at streamlining the communication process for coordinating participation in ALJ hearings. Consistent with OIG's recommendations, CMS will work to enhance participation guidelines for contractors, and will explore establishing guidance on electing party status for ALJ hearings. We will also continue monitoring the results of contractor participation to determine the most effective and efficient use of the resources currently available for this activity. We believe these efforts will increase contractor participation in cases where participation is most needed. OIG also recommended CMS include incentives related to participation in ALJ hearings. We believe, based on CMS' current and future efforts to increase effective and efficient participation, it will not be necessary to include contractual incentives for contractor participation. However, we will explore the possibility of building such incentives into contractors' Statements of Work.

Thank you for the opportunity to review and comment on the draft report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Bartlett served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Rachel Bryan, Christine Moundas, Liz Osius, and Michael Rubin. Central office staff who provided support include Scott Manley and Debra Roush.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.