RESOLVED, That the American Bar Association recommends the following reforms in the Medicare claims adjudication process to assure that Medicare beneficiaries are afforded due process throughout all levels of the claims and appeals process.

I. Early Levels of Review

1. The Centers for Medicare and Medicaid Services (CMS), and its contractors, should provide specific information to beneficiaries on procedures and burdens of proof, including a clear and detailed statement that includes the reasons for denial, the laws and coverage policies relied on for the denial, and the deficiencies of the medical evidence. In addition, CMS and its contractors should be diligent in their efforts to inform beneficiaries about the opportunity to appeal, the availability of representation and the consequences of failing to appeal.

2. In gathering medical evidence, CMS and its contractors should consult the beneficiary’s treating sources, including physicians, psychologists and medical facilities, and compensate adequately for providing relevant medical information. CMS and its contractors should specify the nature of the medical evidence needed to decide a claim and assist the beneficiary in obtaining the specified medical documentation. Great weight and due deference should be given to the opinions of the beneficiary’s treating physician.

3. Congress and CMS should eliminate the second pre-hearing level of appeal (carrier hearing or Qualified Independent Contractor review). Appeals from the contractor’s final decision in the initial determination process should go directly to an Administrative Law Judge.

II. Administrative Law Judge (ALJ) Hearings

A. Protect Administrative Law Judge’s Role as Factfinder

1. Beneficiaries should continue to have a right to an independent ALJ hearing regardless of any other changes to the Medicare appeals process.

2. Beneficiaries should be entitled to a due process hearing, on the record, before an independent Administrative Law Judge appointed pursuant to the Administrative
Procedure Act (APA), applying the statute and published regulations rather than informal CMS or contractors’ policies.

3. Whether or not the beneficiary or government has a representative at the hearing, the ALJ should continue to assist with the development of the factual record. The hearing should not be conducted in an adversarial setting. Neither CMS, nor its contractors, should be a party to the ALJ hearing.

4. ALJs should be obliged to make individualized findings of fact that apprise beneficiaries of the specific basis of decisions.

B. Closing the Record/Submission of Evidence

The record should not be closed prior to the hearing. After the ALJ hearing, beneficiaries should be provided the opportunity to reopen the record for good cause.

III. Medicare Appeals Council (MAC)

1. Beneficiaries should receive prompt notice from the Medicare Appeals Council (MAC) if CMS, or its contractors, appeal an ALJ decision. Neither CMS nor its contractors should be a party to the MAC review.

2. As with the ALJ hearing stage, the MAC should abide by the statute and published regulations, rather than informal CMS or contractors’ policies. Beneficiaries should continue to have a right to an independent MAC review.

IV. Local Coverage Decisions and Local Medical Review Policies

CMS should adopt regulations that require its contractors, when proposing a local coverage decision or local medical review policy, to provide a notice and comment period, and an opportunity for interested persons to testify at any hearing, subject to the APA. The administrative law judge, the Medicare Appeals Council and the federal court should not be bound by contractors’ local coverage decisions or local medical review policies.
Congress created the Medicare program in 1965. Medicare is the federal health insurance program designed to provide affordable health insurance coverage to the elderly and disabled persons in this country. The Centers for Medicare and Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), has primary responsibility for the administration of the Medicare Program. CMS contracts with private insurance companies (“contractors”) to process claims for medical services and supplies. When a claim is partially or totally denied, there is an administrative appeals process available to beneficiaries and health care providers and supplies who are dissatisfied with the initial determinations and subsequent appeals determinations/decisions. There are different appeals processes for Part A claims, Part B claims and Medicare + Choice claims. At some stage in these claims’ appeals processes, the beneficiary or provider is entitled to a hearing before an administrative law judge (ALJ).

Currently, all Medicare administrative law judge hearings are heard by an administrative law judge employed by the Social Security Administration (SSA) pursuant to an agreement between CMS and SSA. Prior to the separation of SSA from HHS 1995, Medicare hearings were held before SSA administrative law judges under HHS’ auspices. The majority of these hearings involves the reasonableness of service and of payment for institutional providers under Part A, medical providers such as doctors, suppliers and other health care providers under Part B, and managed care organizations under Part C. Since 1995, there has been a memorandum of understanding between HHS and SSA that permits SSA administrative law judges to preside at these hearings. In 2000, Congress passed the Benefits Improvement & Protection Act of 2000 (BIPA), which created a new category of administrative law judge hearings for local coverage determinations, and which may have created adversarial hearings for those cases. Regulations proposed on August 22, 2002, but have not been issued as final regulations, provide that the Medicare contractor or CMS may be a party to certain administrative appeals. Although new administrative law judges were supposed to have been hired to hear BIPA cases, no additional judges have been hired and no hearings have occurred.

According to Social Security Administration data, in fiscal year 2001, there were 954 administrative law judges, which heard Social Security retirement and disability, Supplemental Security Income, Medicare and Black Lung cases. Of the 525,636 hearing dispositions in 2001, 85,783 were Medicare matters.

The SSA uses a small cadre of judges to handle the large Medicare class action type of cases, usually brought by health care providers. Although SSA has administrative law judges stationed throughout the country, the majority of these cases are heard in a few sites. Local administrative law judges in the nation’s 139 hearing offices hear the remainder of the cases. If CMS or HHS decides to use another system, it would be imperative to have administrative law judges available nationally.

Currently, SSA and CMS are negotiating to transfer jurisdiction of Medicare appeals to be under the auspices of CMS. In addition, it is anticipated that future legislative changes to the Medicare program will include a transfer of the Medicare appeals process to CMS or HHS. For over fifteen years, the American Bar Association has adopted policies that ensure that claimants and
beneficiaries are entitled to due process throughout the appeals process administered by the Social Security Administration. This policy, if adopted, will address many of the same principles included in those policies but will focus on the Medicare program specifically, rather than the agency who has authority to implement it.

**Early Stages of Review**

In August 1986 and August 1991, the American Bar Association adopted policies to improve the appeals process utilized by the Social Security Administration. This recommendation would apply many of the principles important to the protection of due process in the adjudication of Medicare claims and appeals.

All Medicare beneficiaries have basic notice, appeal and grievance rights, which represent due process. These rights include a clear and concise written notice, which states the reasons for the decision and describes the appeal process available to the beneficiary. The notice should include the medical, legal, and factual basis for the denial, reduction or termination of services. It should provide information on how to file an appeal, the applicable time periods to file the appeal and the types of information needed to support the appeal.

The CMS should assist the beneficiary to gather the medical evidence relevant to the claim. For example, if medical information relevant to the claim is missing from the file, CMS, or its contractors, could send a letter to the provider to request the necessary documents. The opinions and documents of the beneficiary’s treating physician and other health care providers are crucial to the success of a Medicare claim or appeal. CMS and its contractors should give great weight to the opinion of a treating physician because the treating physician knows and observes the patient and is responsible for providing medical care to the beneficiary. In social security cases, the “treating physician rule” had been adopted by all the Courts of Appeals and has been adopted into regulation. 20 CFR §404.1527. Physicians and other health care providers often provide letters of support, laboratory requests and sworn statements to support the claims for medically necessary services and payments when appropriate. CMS and its contractors have the names of the treating, are in the best position to obtain relevant documents and have resources to obtain them.

In 2000, Congress enacted the Medicare, Medicaid, SCHIP Benefit Improvement and Protection Act of 2000 (BIPA) which modifies the Medicare appeals process. In particular, §521 of BIPA establishes a uniform appeals process for Part A and Part B claims and denotes time frames for filing appeals and issuing decisions. The new process, as with the current Part B appeals system that it replaces, has two levels of review before a beneficiary has a right to a face-to-face hearing before an impartial decision maker. Both reviews are on-the-record and neither provides an opportunity for the beneficiary to appear in person or by telephone. Beneficiaries should not be required to endure multiple levels of review before having a hearing before an independent decision maker. The extraordinary delays in processing appeals and the complexity of the process create barriers for many of beneficiaries who often decide to give up and not to pursue their appeal further. The second pre-hearing level of review delays a final adjudication of the claim and provides few advantages to beneficiaries.
Administrative Law Judge Hearings

Courts have recognized at least three broad public policy interests that favor due process hearings to mediate claims and disputes with respect to entitlements such as Medicare: the desire for accuracy, the need for accountability, and the necessity for a decision-making procedure perceived as fair. *Gray Panther v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980). Over the past two decades, the ABA has adopted numerous policies to protect beneficiaries the right to a full due process hearing under the Administrative Procedure Act before an Administrative Law Judge. (See August 1986 and August 1995 policies.) The due process rights of beneficiaries must be protected by ensuring that every beneficiary continues to be entitled to a due process hearing, on the record, before an administrative law judge who can assert authority for development of the record. The ABA has long supported the role of the administrative law judge as special: to develop the factual record and to be the fact finder. This unique role needs to continue.

In making their decisions, administrative law judges should abide by the federal regulations and statute, and not the informal local coverage decisions or local medical review policies developed by CMS’ contractors, which are further discussed below. Currently, neither administrative law judges nor the Medicare Appeals Council is bound by, or give deference to, contractors’ policies, informal CMS’ policies or CMS’ program memoranda. The present regulations require that the administrative law judges and Medicare Appeals Council only base their decisions on the Medicare statute, published regulations and national coverage decisions.

A cornerstone of due process is the ability to submit evidence to the trier of fact. Beneficiaries often do not submit evidence early in the appeals process because, unlike physicians, providers, and suppliers, they do not have medical records and other scientific evidence at their fingertips. They must request the information from the appropriate provider. Even if the Medicare notice they receive explains what information is missing, some beneficiaries do not know how to obtain the information. Some beneficiaries may lack the mental, physical, and/or financial resources to gather the information. Unfortunately, it has been our experience that beneficiaries, and even their advocates, have difficulty getting the necessary medical records from the physicians and providers, who may simply ignore their request. A beneficiary who must repeatedly contact a physician or provider for information may give up in frustration or out of fear of seeming like a pest. Closing the record before the hearing would penalize beneficiaries who may have been unable through no fault of their own to gather evidence necessary for a full and fair hearing and would undermine the ALJ role as fact finder. It is crucial that the record remain open to allow the beneficiary, who is often not represented by counsel, to submit evidence and documentation at the administrative law judge hearing, or after the hearing for good cause.

Medicare hearings should continue to be conducted in non-adversarial settings. The Medicare appeals system is an informal process, with the administrative law judge serving to develop the evidence and investigate the facts, and to rule on the record before him or her. It has been proposed that CMS participate in the administrative law judge hearing, potentially as an interested party. In the current non-adversarial process, CMS’ role is to ensure that payment is made to or on behalf of eligible beneficiaries where services are both covered and medically necessary. Participation by CMS at the administrative law judge hearing changes this role, and makes CMS the adversary of any beneficiary or other party who seeks coverage of and payment
for items or services. The government advocate would be present not to help the administrative law judge ascertain the true facts, but to present CMS’ position in the case.

The experience of the Social Security Administration in the Government Representation Project (GRP) during the mid-1980's demonstrates that representation at the administrative law judge hearing will not achieve the agency’s goals. During Congressional hearings conducted in 1985 and 1986, witnesses testified that, as a result of GRP, (1) processing times were lengthened; (2) the quality of decision-making did not improve; (3) cases were not better prepared, and (4) the government representatives generally acted in adversarial roles. In addition to radically changing the nature of the process, the financial costs of representing CMS at the administrative law judge level would be very high. In the mid-1980's, the cost to SSA of representation for the five offices where the GRP pilots were conducted was $1 million per year, according to testimony given by the agency at a hearing before the House Ways and Means Committee in 1986.

Medicare Appeals Council

The due process rights previously discussed with regard to the early levels of the Medicare appeals process are applicable at the Medicare Appeals Council (MAC) review. Presently, the MAC responsibility is to review ALJ decisions for legal sufficiency and legal authority. As does the SSA Appeals Council, it operates like an appeals court. Under §521 of BIPA, the nature of the MAC review would change to a *de novo* review. There is an enhanced opportunity for oral argument and potential for submission of additional evidence. Provisions must be made for the MAC to manage the gathering of any additional evidence and make a decision, similar to the ALJ process. In making its decisions, MAC should abide by the regulations and statute, and not the informal local coverage decisions or local medical review policies discussed below.

Local Coverage Decisions and Local Medical Review Policies

Local coverage decisions (LCD) and local medical review policies (LMRP) are guidelines that describe when and under what circumstances Medicare will pay for a medical service, item or procedure. The local policies identify the diagnosis for which each procedure/supply will be paid. Every Medicare carrier and fiscal intermediary has the authority to develop and adopt its own local coverage policy, which would be applied in the respective geographic jurisdiction. Consequently, a Medicare beneficiary’s access to services are dependent on where the beneficiary lives and what local policies are in effect. LCDs and LMRPs have the most significant impact on access to Medicare covered services. Currently, there are over 8,000 LCDs and LMRPs in existence.

There are no published regulations that establish standards and procedures for the contractors to develop their LCDs or LMRPs. Until recently, the development of LCDs and LMRPs was a closed process, with limited opportunity for public comment. In November 2000, CMS (then, HCFA) issued a program memorandum instructing contractors to establish an open and public LMRP development process. The memorandum requires contractors to solicit and accept comments from providers and members of the general public. In addition, contractors must allow interested parties, including beneficiaries, to make presentations at the Carrier Advisory Committee (CAC) hearings on a proposed LMRP. However, many CACs require an individual
to submit written testimony before the hearing and only upon its review of the testimony, will the individual be considered or approved to present at the hearing.

The Medicare program manuals require that local coverage policies be supported by published authoritative evidence derived from definitive trials or studies, general acceptance in the medical community, consensus of expert medical opinion or medical opinion derived from consultations with medical associations or other health care experts. Yet, few of these policies identify any medical or clinical basis to substantiate the restrictions on coverage. Although Medicare program manuals require carriers and intermediaries to adhere to the provisions of these informal policies, CMS does not review the policies to assure adherence to or consistency with CMS manuals or federal regulations and laws, resulting in divergent local coverage policies across the country. As previously noted, the administrative law judges, the Medicare Appeals Council and the federal courts are not bound by these local coverage decisions or policies.

Respectfully submitted,

Dean Kristin Booth Glen
Chair
Commission on Law and Aging
August 2003
1. **Summary of Recommendation(s)**

   This proposed policy recommends specific reforms in the Medicare claims adjudication process to assure that Medicare beneficiaries are entitled to due process throughout all levels of the claims and appeals process. These reforms address 1) procedures at the Early Levels of Review; 2) Administrative Law Judge hearings; 3) the Medicare Appeals Council; and 4) Local Coverage Decisions and Local Medical Review Policies.

2. **Approval by Submitting Entity**


3. **Has this or a similar recommendation been submitted to the House or Board previously?**

   No.

4. **What existing Association policies are relevant to this recommendation and how would they be affected by its adoption?**

   - In August 1976, the Association adopted policy to reaffirm its commitment to the independence and impartiality of Administrative Law Judges, and to urge the Civil Service Commission to take further steps to ensure that agencies engage in no disciplinary actions affecting the independence or impartiality of Administrative Law Judges. Further, that the Civil Service Commission should promulgate regulations providing an appropriate review procedure before the Commission if an agency engages in any disciplinary action against an Administrative Law Judge, which has the purpose or effect of impairing such independence or impartiality.

   - In August 1986, the Association adopted policy to support efforts to improve the administrative process utilized by the Social Security Administration in accordance with principles recommended by the Symposium on Federal Disability Benefit Programs.

   - In August 1986, the Association adopted policy that opposed the enactment of H.R. 4647, H.R. 4419, and similar legislation to create an Article I Social Security Court to hear appeals from final decisions of the Social Security Administration.
• In August 1988, the Association adopted policy to support efforts to improve the administrative and judicial process utilized by the Department of Health and Human Services in accordance with principles recommended by the Symposium on Medicare Procedures.

• In August 1991, the Association adopted policy to urge Congress to enact legislation amending the Social Security Act to require the Secretary of Health and Human Services to implement certain practices at the initial determination process of disability claims. The policy also urged Congress to enact legislation amending the Social Security Act to require the Secretary of Health and Human Services take specific affirmative steps to ensure that applicants unable to adequately access the Social Security system, in particular homeless people, receive assistance in applying for benefits to which they may be entitled.

• In August 1995, the Association adopted policy to support reforms in the Social Security disability adjudication process to eliminate the backlog that threatened the ability of Social Security Administrative Law Judges to assure due process.

• In August 2000, the Association adopted policy to urge Congress, when it considers enactment of legislation relating to new or existing programs that involve agency adjudications with an opportunity for a hearing, to consider and determine expressly within the relevant legislation whether the hearing should be subject to the requirements of the Administrative Procedure Act, including presiding officer protections, ex parte prohibitions, record-based decision-making, and other procedural safeguards.

This policy, if adopted, will address many of the same principles included in the aforementioned American Bar Association policies, but will focus on the Medicare program specifically.

5. What urgency exists which requires action at this meeting of the House?

Currently, all Medicare Administrative Law Judge (ALJ) hearings are held under the auspices of the SSA. The SSA and CMS are negotiating to transfer jurisdiction of Medicare appeals to be under the auspices of HHS or CMS. In addition, it is anticipated that future legislative or regulatory changes to the Medicare program will include a transfer of the Medicare appeals process to CMS or HHS.

6. Status of Legislation (if applicable)

There is no applicable legislation pending at the current time.

7. Cost to the Association (both direct and indirect costs.)
None.

8. **Disclosure of Interest** (if applicable)

   None.

9. **Referrals**

   Simultaneously with this submission, referral is being made to:
   All Sections and Divisions

10. **Contact Person** (prior to the meeting)

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11. **Contact Person** (who will present the report to the House)

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