



CHANGES TO THE MEDICARE ADMINISTRATIVE LAW JUDGE HEARING PROCESS

This Alert, the second in a series, addresses changes to the administrative law judge (ALJ) hearing process contained in interim regulations issued by the Centers for Medicare & Medicaid Services (CMS) on March 8, 2005. 70 Fed. Reg. 11420 (March 8, 2006). The changes pertain to ALJ hearings for all Medicare claims, including managed care claims and future prescription drug claims.

As reported in previous Alerts, the Department of Health and Human Services (HHS) is in the process of implementing the provisions of the Medicare Prescription Drug, Improvement and Modernization Act which require the transfer of ALJs to HHS from the Social Security Administration (SSA). Separate and apart from the transfer efforts, the CMS interim final regulations change the nature of the ALJ hearing from a beneficiary-friendly process to a process that is more legal and adversarial. Taken together, these two changes raise questions about whether beneficiaries will continue to receive an impartial and fair review of their Medicare claims.

Filing a request for an ALJ hearing

As noted in last week's Alert, any party to a reconsideration by the qualified independent contractor (QIC) may file a request for an ALJ hearing within 60 days of receipt of an unfavorable QIC decision. A party may also request that the claim be escalated to the ALJ level if the QIC has not acted on the reconsideration within the statutory 60-day time frame. Notice of the appeal must be filed with the other parties to the QIC review or else the statutory time frame for deciding an ALJ appeal is tolled. If more than one party files a hearing request, the requests will be consolidated. Hearing requests must be filed with the entity identified in the reconsideration notice.

Participants at the hearing

In addition to the parties to the QIC reconsideration, the regulations allow CMS or its contractors to participate in the ALJ hearing to varying degrees. CMS may simply participate in a hearing at the request of the ALJ or at its own request. If CMS participates, CMS can file position papers or provide testimony to "clarify factual or policy issues," but the agency cannot call witnesses or cross-examine witnesses. If CMS participates it cannot be called as a witness.

CMS may also act as a party where it can also call witnesses, cross-examine witness, and submit evidence. (Note that other parties to the hearing generally are limited in their ability to submit evidence at the ALJ stage.) CMS cannot enter as a party if the request for a hearing is filed by an

unrepresented beneficiary, but the regulations do not address the issue of CMS acting as a party where there is an unrepresented beneficiary and a provider filing separate appeals.

Time frames for deciding an appeal before an ALJ

The Medicare statute says that an ALJ must decide a hearing request within 90 days of receipt unless the party requesting the hearing files a motion or stipulation requesting a waiver of that time period. The interim final regulations modify the statutory time frame by:

- Providing that the 90 days run from the date of receipt by the entity named in the QIC reconsideration. Thus, if the beneficiary files at another location such as the Social Security office, the time frame will automatically be extended.
- Automatically extending to 180 days the time to decide an escalated appeal. The statute makes no such provision, and such an extension defeats the purpose of escalation.
- Tolling the 90 days for the period between the time a party was supposed to submit evidence and the time it is received.
- Tolling the 90-day period when CMS is a party and another party requests discovery.

Time and place for a hearing

One of the most dramatic changes made by the regulations is to virtually eliminate the beneficiary's right to a face-to-face in-person hearing with the ALJ. The regulations state that an ALJ hearing may be held by video teleconferencing (VTC), by telephone, or in-person. They give the ALJ discretion to set the time and place of the hearing and create a presumption that the hearing will be held by VTC if the equipment is available.

If the beneficiary requests an in-person hearing, the ALJ has discretion, after consulting with the managing attorney in the regional field office, to grant the request if good cause is shown. However, the request, and not the granting of the request, for an in-person hearing constitutes an automatic waiver of the 90-day time frame to decide the appeal. Further, even if the request is granted and the beneficiary appears in person, other participants in the appeal, including medical examiners and CMS, may still appear by VTC or telephone.

Prehearing case review of evidence

Again, the regulations limit the ability of providers, suppliers, and beneficiaries represented by a provider or supplier to submit evidence after the QIC reconsideration level. Evidence submitted at the ALJ level is to be submitted with the request for a hearing or 10 days thereafter. The regulations require the ALJ to review evidence submitted with a hearing request to determine whether good cause exists for the late submission. The ALJ may reject evidence if good cause is not shown, or remand the appeal to the QIC.

However, the regulations do not state that the beneficiary has a right to review evidence before the hearing, but state that a party may review the record at the hearing or at a time set by the ALJ if no hearing. A party who requests a copy of all or part of the record may have to pay costs. In addition, if a party requests all or part of the record and an opportunity to comment on the record, the time from date of receipt of that record until the expiration of the time granted for the response doesn't count toward the 90 days.

Issues before the ALJ

The ALJ can consider issues decided in favor of beneficiary at lower levels if evidence causes the ALJ to question the decision and the ALJ notifies the parties. The ALJ may also consider new issues at hearing if he or she notifies the parties; new issues can arise from CMS participation.

The ALJ may grant a request for discovery only when CMS participates as a party. Discovery is limited to the reasonable production of documents; depositions are available only if the deponent agrees or the ALJ finds a deposition necessary to secure a party's testimony. A party may not request interrogatories or requests for admission. The ALJ will deny a request for discovery if the matter is privileged or protected from disclosure. If the ALJ grants a discovery request, the 90 day time period is tolled.

Applicability of National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)

The regulations make clear that an ALJ is to apply the LCD or NCD which was in place on the date the item or service was provided. Thus, a beneficiary will not be able to take advantage of a change in coverage rules.

An NCD is binding on all contractors, including QICS, Medicare Advantage plans, prescription drug plans, ALJs, and the Medicare Appeals Council. ALJs and MAC cannot set aside an NCD. However, they can review the facts of a case to determine whether the NCD applies.

The regulations give LCDs and other CMS policies greater weight than they have been accorded in the past. Although the regulations state that the policies are not binding, they require the ALJ and the MAC to give them substantial deference. Further, if an ALJ or the MAC decide not to follow an LCD or other guidance, the decision must explain why the guidance is not followed. The regulations note that an ALJ or the MAC cannot set aside an LCD or policy in the claims appeals procedure; a claimant must use procedure in 42 C.F.R. Part 426 to challenge the validity of the LCD.

Escalation of a claim to the Medicare Appeals Council (MAC)

An appellant, other than CMS when CMS is a party, can request, in writing, escalation to the MAC when the ALJ does not issue a timely decision. The appellant must send a copy of the request to any other parties in the case. The ALJ has 5 days to act on the case or to send it to the

MAC. As at the ALJ level, the time for the MAC to act on an escalated case increases from 90 to 180 days.

The Center will continue its series of Weekly Alerts on the Medicare appeals process over the next few weeks. Advocates with questions should contact Vicki Gottlich (vgottlich@medicareadvocacy.org) and Alfred Chiplin (achiplin@medicareadvocacy.org) in the Center's D.C. office, 202-216-0028, or Brad Plebani (bplebani@medicareadvocacy.org) in the Center's Connecticut office (860-7790).