Part B Claims – Substantive and Sampling

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A YEAR IN REVIEW OF RELEVANT FEDERAL CASE LAW AND MEDICARE APPEALS COUNCIL DECISIONS IMPACTING PART B PROVIDERS

The purpose of this session is to provide a year in review of the federal case law and Medicare Appeals Council ("Appeals Council") decisions impacting Medicare Part B providers. The year in review will begin with a review of the Office of Inspector General's ("OIG") Work Plan for the 2014 fiscal year in order to assess what areas the OIG will deem to be important for Part B providers in the coming year. The year in review will then focus on relevant federal and Appeals Council cases impacting Medicare Part B providers, including the case of *Jimmo v. Sebelius*, which led to significant "clarifications" in the way Medicare contractors review physical therapy services. Next, the year in review will include Medicare Appeals Council cases addressing issues related to provider without fault and waiver of liability defenses. In concluding, the session will then assess a series of recent Medicare Appeals Council cases in order to discern recent trends in dismissals for failing to notify beneficiaries of the Administrative Law Judge ("ALJ") hearing request.

I. OIG WORK PLAN FOR FISCAL YEAR 2014

The purpose of the OIG Work Plan for Fiscal Year 2014 ("Work Plan") is to summarize new, current, and future reviews that the OIG plans to pursue with respect to Health and Human

Services ("HHS") programs for 2014.[1] The goal of the OIG is to protect the integrity of HHS programs and the well-being of beneficiaries.[2] The OIG seeks to accomplish this goal by preventing fraud and abuse in order to increase efficiency.[3] This review seeks to identify and raise awareness about upcoming OIG issues that will have an impact on Medicare Part B providers.

Medicare Part B covers designated practitioners' services, outpatient care, and certain Medicare services and equipment that have traditionally not been covered by Medicare Part A.[4] One area in which the OIG will focus on in 2014 is "questionable billing patterns for Part B services during nursing home stays." Specifically, the OIG will seek to find and review questionable billing practices related to nursing home stays not covered by Part A. Specifically, the target of these reviews will be those stays in which the 3-day stay requirement prior to an inpatient stay is not met, and stays during which the beneficiary's benefits are exhausted.[5]

The OIG will review Power Mobility Device ("PMD") payments to determine whether the face-to-face requirements have been met. To establish the medical necessity for the PMD, the patient's treating physician must conduct a face-to-face examination prior to prescribing the PMD. The physician may receive an add-on payment (added on to the evaluation and management service payment) when the physician documents the need for the PMD. In the past, the OIG has found that the PMD claim was often denied when the add-on payment code was not billed by the treating physician.[6]

[1] *OIG Work Plan for Fiscal Year 2014*, at 1.
[2] *Id.*
[3] *Id.*
[4] *Id.* at 17.
[5] *Id.* at 24.
[6] *Id*. at 12.

Prior OIG work found that suppliers of nebulizer machines and related drugs were overpaid by approximately $46 million. The DME MACs have issued local coverage determinations ("LCDs") containing utilization guidelines and documentation requirements. The OIG will review payments for nebulizer machines and related drugs to determine whether claims for these items are medically necessary and in accordance with the utilization guidelines and documentation requirements contained in the LCDs.[7]

Another Part B provider type on the OIG's radar is providers of ground ambulance transport services. In response to the OIG previously identifying overutilization trends and payments for medically unnecessary services, the OIG will be scrutinizing providers of ground ambulance transport services paid by Medicare Part B in an effort to identify vulnerabilities, inefficiencies and fraud related to these services.[8]

Suppliers of portable x-ray equipment will also see increased scrutiny by the OIG to determine whether payments for transportation and setup were correct and supported by the documentation. The OIG will also review these claims to determine whether the services were ordered by a physician, as opposed to being ordered by nonphysicians which is not covered by Medicare.[9]

The OIG will also look into billing characteristics and questionable billing practices regarding laboratory tests.[10] Laboratory tests should only be ordered by either a physician or qualified practitioner who is treating the beneficiary.[11] The OIG stated its reasoning for looking at billing practices for laboratory tests is due to the recent increase in lab spending as a result of

[7] *Id*. at 13.
[8] *Id*. at 14.
[9] *Id*. at 20.
[10] *Id.* at 34.
[11] *Id.* at 34; see also 42 C.F.R. § 410.32.

increased volume of ordered services, as well as the fact that Medicare is the largest payor of clinical lab services in the United States.[12]

Billing and payments related to evaluation and management ("E/M") services, an area that has seen increased audit activity over the years, is also included in the 2014 OIG Work Plan. The OIG will determine the extent to which selected E/M payments were inappropriate. In addition, the OIG also plans to determine whether electronic or paper medical documentation presented greater vulnerabilities by reviewing multiple E/M services associated with the same providers and beneficiaries.

Overall, based on the OIG Work Plan for Fiscal Year 2014, Medicare Part B providers can expect the usual increase in scrutiny of payments made to them in an effort to curb fraud, waste and abuse.

II. FEDERAL COURT CASES

Three cases are currently pending in the United States District Court of the Southern District of Indiana that center on the same issue: whether the "DSPA test," a laboratory test performed by Strand Analytical Laboratories ("Strand"), an independent clinical laboratory, is medically necessary and constitutes a covered service reimbursed by Medicare. In each of these cases, based on an undisputed administrative record, the ALJ found that DSPA testing is reimbursable by Medicare as a diagnostic test that is used in the diagnosis and treatment of prostate cancer. In each case, the ALJ decision was reversed by the Medicare Appeals Council. Strand has appealed each case to the Southern District of Indiana, where they are currently pending.

The record in these cases showed that DSPA testing plays a unique role in the testing cycle for prostate cancer. The testing cycle invariably leads to an alarmingly high rate of "occult

[12] *Id.*

provenance error," which is an error of an unknown origin causing specimen mix-up or contamination.[13] The effect of an undetected "occult provenance error" is that a treating physician could misdiagnose or mistreat beneficiaries who are suspected of having prostate cancer. DSPA testing is the only test available to eliminate occult provenance error by confirming that the tissue samples taken from the beneficiary belonged to that beneficiary and had not been contaminated or mixed-up with other tissue samples. This error is not otherwise prospectively identifiable by a laboratory. Strand performed the DSPA test based on an order by the beneficiary's treating physician upon a putative positive finding of prostate cancer.

In addition to submitting journal articles and physician statements, Strand proffered live expert witness testimony from both a nationally renowned urologist and pathologist that described the nature of occult provenance error and the role of DSPA testing in eliminating that error to diagnose and treat prostate cancer. They testified that the DSPA test is integral to the accurate diagnosis and appropriate treatment decisions made by the treating physician. They also emphasized that the diagnostic nature of DSPA testing was supported by the fact it was performed based on a physician order limited to only specimens that tested putatively positive for cancer. In other words, it was not a federally-mandated, routine "quality assurance" process within the laboratory.

These cases raise several important issues to be decided by the federal district court. For example, first, in the face of a comprehensive administrative record developed before the ALJ, where there was no participation by CMS, the MAC arguably improperly re-weighed the

[13] In addition to those incidents such as extraneous tissue or sample switches which may be caught by the pathologist, there exist occult specimen provenance complications ("SPC") which occur in the absence of a direct indication of a specimen switch occurring. SPCs arise at any phase of the surgical pathology testing cycle, including the pre-analytical phase which is completely outside the control of the pathology laboratory. A recent Washington University Study measured the incidence of SPCs statistically correlated to the pathology laboratory setting to be as high as 3.51%

evidence and dismissed the record as insufficient to support the medical necessity of DSPA testing and to support the conclusion that DSPA testing is a covered service. Even taking into account the deference afforded to the Appeals Council in federal district court review of an agency action, these cases will require the court to carefully examine the outer limits of this deferential standard. Second, the Appeals Council expanded the administrative record with additional evidence submitted by the AdQIC in its Referral to the Appeals Council. There is a question whether this expansion of the record was proper and tainted the Appeals Council's decision. Third, the Appeals Council appeared to adopt a heightened standard by deciding whether DSPA testing "directly" diagnosed "and" treated prostate cancer, where "directly" is not found in the controlling statute and in order to be diagnostic a test can be used to diagnose "or" treat. The federal court will have to determine whether the Appeals Council consistently applied the proper statutory and regulatory standards in reviewing the ALJ's decision.

In *Woodfill v. Secretary of Health and Human Sservices*, a recent case that made its way up to the Sixth Circuit Court of Appeals, the Court affirmed the decision of the Department of Health and Human Services ("HHS") to deny coverage of an implantable infusion pump in accordance with a Medicare national coverage determination ("NCD").[14]. The plaintiff suffers from a degenerative spinal disease and, in order to alleviate her pain, her doctors recommended an implantable infusion pump designed to deliver pain medication directly into the spinal cord. The plaintiff previously had a spinal cord simulator installed in the mid-1990s to offer some pain relief. The plaintiff's insurance provider through the Medicare Advantage Program denied coverage of the implantable infusion pump. The denial was appealed by the plaintiff and was upheld at each level of the Medicare appeal process, including federal district court.

[14] *Woodfill v. Secretary of Health and Human Services*, No. 13-3729 (6th Cir. Feb. 27, 2014).

In affirming the district court's decision, the Sixth Circuit relied on an NCD which permits coverage for an implantable infusion pump; however, the NCD also provides that the pump "is contraindicated" for patients with "other implanted programmable devices since crosstalk between the devices may inadvertently change the prescription." The Court noted that, through this limitation, the Secretary has categorically excluded implantable infusion pumps from coverage where a patient has already received an implanted electronic devise. Although the plaintiff argued that the pump did not present any risk of crosstalk and therefore the NCD's exception did not apply to her, she did not challenge the interpretation of the NCD's categorical bar, but rather only the rationale behind the bar. The Court upheld the decision of the lower court, finding that the Secretary did not abuse her discretion in applying the categorical bar in this case. In upholding the decision of non-coverage, the court stated, "[t]hese facts may well suggest that the [NCD]'s categorical bar deserves further consideration. But this action is not the route for reconsidering the bar."

Jimmo v. Sebelius is one of the seminal Medicare cases of 2013. While the case settled, and as a result was not formally adjudicated, the settlement has had wide ranging effects. On January 24, 2013, the United States District Court for the District of Vermont approved the settlement agreement in this case.[15] In *Jimmo*, the plaintiffs, the Center for Medicare Advocacy ("CMA") alleged that Medicare contractors improperly denied valid claims involving skilled care, which includes outpatient physical therapy services.[16] Specifically, the plaintiffs alleged that the denials were based on a rule-of-thumb "Improvement Standard" whereby otherwise valid claims for skilled care, including physical therapy, would be denied due to patient's lack of

[15] *Jimmo v. Sebelius Settlement Agreement* Fact Sheet, 1 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf
[16] *Id.*

restoration potential.[17] The plaintiffs' contention was that this was in error due to the fact that the patients required skilled care to prevent further deterioration of their condition.[18]

CMS noted that while it is reasonable to expect improvement when evaluating a claim where the goal of the treatment was restoring a prior capability, there may be instances where no improvement can be expected, but skilled care remains necessary to prevent further deterioration.[19] As such, although physical therapy services will always be evaluated to determine whether the services were medically necessary and reasonable, the restoration potential of a patient is not a deciding factor in determining the need for the skilled care of a physical therapist.[20]

Jimmo's settlement agreement resulted in a few significant actions and policy changes that are noteworthy for Medicare Part B providers. First and foremost, CMS revised its program manuals relating to skilled care. These revisions were issued on January 14, 2014.[21] In revising the manuals, CMS sought to clarify the language so as to make sure the intent of the policy is fully carried out. As a result of the settlement agreement, the revisions specifically clarified that coverage of skilled therapy "does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care."[22] To further comply with the provisions of the Settlement Agreement, CMS undertook an educational campaign to educate contractors, adjudicators, ALJs, and agency staff on changes to the policy.[23] Finally, CMS is conducting a claims review in which random samples of skilled nursing, home

[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id*; see also 42 CFR 409.32(c).
[21] Medicare Benefit Policy Manual, Chapter 15, §220.2.B. See also Medicare Benefit Policy Manual, Chapter 8, §30.3. See also Medicare Benefit Policy Manual, Chapter 7, §20.1.2
[22] *Id.*
[23] *Jimmo v. Sebelius* Fact Sheet.

health and outpatient physical therapy coverage decisions are reviewed to ensure that beneficiaries received their entitled care.[24]

III. MEDICARE APPEALS COUNCIL CASES: WAIVER OF LIABLITY AND PROVIDER WITHOUT FAULT CLAIMS

The statutory authority for "waiver of liability" defense is set forth in § 1879(a) of the Social Security Act.[25] Waiver of liability relieves a provider of liability for an overpayment if the provider "did not know and could not reasonably have been expected to know that payment would not be made."[26] Furthermore, the waiver of liability defense can be used for services denied as not medically necessary for certain custodial care or homecare determinations.[27] According to the Medicare Program Integrity Manual, CMS defines "sufficient notice" to include any of the following: (1) previous denials for the same service; (2) publication by the contractor in a newsletter or other communication to the provider community that a service is considered not reasonable and necessary or constitutes custodial care; (3) knowledge based on experience; or (4) local standards of practice.[28] It is important that providers and their legal counsel are aware of all relevant publications and guidance on the local and national level.

In its relevant parts, § 1870 of the Social Security Act states that a provider will not be responsible for refunding an overpayment where the provider was "without fault" with regard to causing the overpayment.[29] A key difference between the "waiver of liability" defense and the "provider without fault" defense is that the "provider without fault defense is not limited to certain types of claims.[30] Unlike § 1879(a), § 1870 is not limited to claims denied under §

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[24] *Id.*
[25] 42 U.S.C. § 1395pp; *see also* Medicare Claims Processing Manual Pub. 100-04, Chapter 30, Section 20.
[26] 42 U.S.C. § 1395pp.
[27] *Id.*
[28] Medicare Program Integrity Manual, Pub 100-08, Exhibit 14.
[29] 42 U.S.C. § 1395gg.
[30] Medicare Financial Management Manual, Pub. 100-06, Chapter 3, Section 70.3.

1862(a)(1) of the Act for not being reasonable or necessary.[31] Rather, § 1870 establishes the entire system for determining who is liable for the overpayment and whether or not the overpayment can be waived.[32] However, the provider without fault defense is only available for overpayments, not for claims denied on a prepayment basis. The regulations further state that a provider will be considered to be "without fault" if they exercised reasonable care in billing for and accepting payment for the services at issue.[33] Undergoing this analysis, the provider must have performed the following: (1) made full disclosure of all material facts; (2) had a reasonable basis for assuming the payment was correct based upon all of the information available to the provider, including without limitation, Medicare instructions and regulations; and (3) brought the issue to the attention of the fiscal intermediary or carrier if it hand any reason to question the payment.[34] Besides "formal" communications from Medicare contractors, communications between CMS and an individual provider can be helpful in arguing that the provider had a reasonable basis for believing that the payment was correct. It is important that providers document and maintain records of any conversations with representatives or its contractors. Absent evidence to the contrary, providers are deemed to be "without fault" if an overpayment is discovered more than three years after it was paid.[35]

Recent cases decided by the Appeals Council are illustrative of what providers can expect in 2014 and beyond. Per the usual course, providers asserting the defenses of "waiver of

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[31] *Id.*; *see also In the Case of (Appellant) (Beneficiaries) NHIC (Contractors) Claim for Supplementary Medical Insurance Benefits (Part B)* 2013 WL 7217921 (H.H.S.) ("Accordingly the issue of waiver of liability under section 1879 of the Social Security Act is moot [as it pertains to these claims], as the services were not denied based upon a finding that they were not reasonable and necessary.").
[32] *Id.*
[33] Medicare Financial Management Manual, Pub. 100-06, Chapter 3, Section 90.
[34] *Id.*
[35] 42 U.S.C. § 1395gg. Please note that pursuant to the RAC Statement of Work, RACs are specifically prohibited from identifying an overpayment where the provider is considered a Provider Without Fault. If a provider is without fault for the overpayment, liability shifts to the beneficiary. Consequently, a RAC is not permitted to attempt to recoup an overpayment from a beneficiary.

liability" and "provider without fault" can expect scrutiny regarding their documentation practices and an increasing reliance on the doctrine of constructive notice by the government.

The case of *Dr. Joseph Motta, M.D.*[36] is illustrative of the increased documentation scrutiny that Medicare Part B providers will be subject to in asserting "waiver of liability" or "provider without fault" defenses. Dr. Motta's case involved a review of the ALJ's decisions and a reversal based on a material error of law to each claim.[37] The impetus for this case is an overpayment determination by a Recovery Audit Contractor ("RAC") in 2007. In reversing the ALJ's decision and upholding the overpayment determination, the Appeals Council focused on the lack of documentation by Dr. Motta.[38] Specifically, the court found that Dr. Motta did not, as required, submit documentation to substantiate that the services billed to the program were covered. The Appeals Council also found that Dr. Motta billed, and that Medicare paid, for services that the provider should have known were not covered.[39] The Appeals Council was persuaded by CMS's argument that Dr. Motta could not rely on Medicare's payment of improperly billed claims as a basis for waiving recoupment under § 1870 of the Act.[40] Overall, this case shows that the Appeals Council will hold providers to strict documentation standards and will hold providers liable for payments they should have known were not covered.

This leads to another issue the Appeal Council has been addressing in recent cases – the issue of constructive notice. An illustrative case is *Barnes Healthcare Services*.[41] At issue in *Barnes* was Medicare coverage for a high strength, lightweight manual wheelchair.[42] The ALJ

[36] *In the Case Joseph Motta, M.D. (Appellant) (Beneficiary) National Government Services (Contractor) Claim for Supplemental Insurance Benefits (Part B)* 2013 WL 3711401 (H.H.S.).
[37] *Id.* at *1.
[38] *Id.* at *6.
[39] *Id.* at *9.
[40] *Id.* at *8.
[41] *In the Case of Barnes Healthcare Services (Appellant) (Beneficiary) Cigna Government Services (Contractor) Claim for Supplementary Medical Insurance Benefits (Part B),* 2013 WL 7094069 (H.H.S.)
[42] *Id.* at *1.

determined that pursuant to § 1862(a)(1) of the Social Security Act, Medicare did not cover the item and that the appellant was liable for the non-covered charges. The ALJ further determined that the beneficiary's liability was waived due to § 1879 of the Social Security Act; as a result, the appellant was not eligible for a waiver because the appellant was presumed to have had knowledge of published Medicare rules.[43]

In upholding the ALJ's decision, the Appeals Council relied heavily on the doctrine of constructive notice.[44] The Appeals Council held that a supplier has actual or constructive knowledge of non-coverage upon "[i]ts receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from [Medicare contractors]."[45] The Appeals Council further held that actual or constructive notice existed based upon a providers' "knowledge of what are considered acceptable standards of practice by the local medical community."[46] After providing the relevant definitions, the Appeals Council found that *Barnes* should have known that the payment would not be made as they did not demonstrate that the product in question was reasonable or necessary.[47]

Another such case decided by the Appeals Council was *Apria Healthcare*.[48] This case considered coverage for the monthly rental fee of standard (manual) wheelchairs.[49] The ALJ denied Medicare coverage due to § 1862 of the Social Security Act and Medicare guidelines because the items were not medically reasonable and necessary.[50] The ALJ further held that the beneficiaries were not liable for the non-covered charges under § 1879 of the Social Security

[43] *Id.* at *3.
[44] *Id.* at *3.
[45] *Id.*
[46] *Id.*; *see also* 42 C.F.R. §§ 411.406(e)(1), (3).
[47] *Id.*
[48] *In the Case of Apria Healthcare (Appellant) (Beneficiary) Noridian Administrative Services LLC (Contractor) Claim for Supplementary Medical Insurance Benefits (Part B)* 2013 WL 7160082 (H.H.S.).
[49] *Id.* at *1.
[50] *Id.*

Act.[51] In upholding the ALJ's decision that Medicare did not cover the wheelchairs at issue in this case, the Appeals Council also modified the rationale for upholding the denials and the finding of liability.[52] Besides scrutinizing the documentation patterns, whereby the Appeals Council determined that merely signing the form is not conclusive evidence that an item is medically reasonable and necessary, the Appeals Council also upheld the denial of coverage based on the constructive notice doctrine.[53] Again, the Appeals Council set out the definition of constructive notice as it did in *Barnes* and found that through receipt of published Medicare rules and regulations, the appellant knew or should have known about the coverage requirements and therefore was liable for the non-covered charges.[54]

The preceding cases are helpful to show that, when presented with such documentation and constructive notice issues, the Appeals Council will hold appellants to strict documentary standards and find constructive notice where actual notice does not exist. Providers should therefore ensure that their documentation meets CMS standards and requirements for reimbursement. Ignorance of published standards is not a valid defense.

IV. MEDICARE APPEALS COUNCIL CASES REGARDING NOTICE OF ALJ HEARING REQUEST

This section focuses on recent Appeals Council cases involving issues relating to what a Notice of ALJ hearing to beneficiaries entails. The recent trend is for some ALJs to dismiss cases on technical grounds for failure to comply with the notice to beneficiary requirements. For purposes of notification, federal regulations require an appellant to send a copy of the ALJ

[51] *Id.*
[52] *Id.*
[53] *Id.* at *4
[54] *Id.* at *9.

hearing request to all parties to the QIC reconsideration appeal.[55] The regulations further state that failure to notify the other parties of the ALJ hearing request will toll the ALJ's 90 calendar day adjudication deadline until all parties receive notice of the requested ALJ hearing. Although the regulations provide that failing to notify the beneficiaries will result in a delay of the 90 day adjudication period, some ALJs have dismissed cases for failing to comply with the ALJ's somewhat ambiguous instructions for notifying the beneficiaries. According to the recent Office of Medicare Hearings and Appeals (OMHA) Medicare Appellant Forum, roughly 28% of cases are dismissed at the ALJ level of appeal.

In *Mat-Su Regional Medical Center, Mat-Su* appealed an Order of Dismissal issued by an ALJ on grounds that the appellant failed to perfect its ALJ hearing request by failing to comply with the ALJ's directions contained in the Notice of Hearing.[56] The ALJ's letter stated that under the regulations, the appellant was required to, but did not, send a copy of the hearing request to the beneficiary. On appeal, the Appeals Council found that the appellant did in fact comply with the ALJ's instructions by submitting a "letter to the beneficiary," a "U.S. Postal Service receipt" showing delivery of the letter to the beneficiary's address, and a facsimile confirmation showing that the appellant transmitted copies of these documents as proof of compliance to the ALJ within the 60-day deadline.[57] In so finding, the Appeals Council held that despite there being no indication that "full copies" were furnished, the appellant nonetheless complied with the ALJ's instructions and should not have had their case dismissed.[58] This case is in the minority however in that in most other instances the Appeals Council has upheld the dismissals for failures to comply or with failures to cure.

[55] 42 C.F.R. §405.1014(b)(2).
[56] *In the case of Mat-Su Regional Medical Center*; Docket No: M-13-1389.
[57] The appellant also provided proof of delivery to the MAC, although the administrative record did not show that proof of delivery was provided to the ALJ.
[58] *In the case of Mat-Su Regional Medical Center*; Docket No: M-13-1389.

One case where the Appeals Council upheld a dismissal for failure to comply with the ALJ's order is *St. Camillus Health & Rehabilitation Center*.[59] St. Camillus appealed an Order of Dismissal issued by an ALJ on grounds that St. Camillus failed to perfect its hearing request by failing to comply with an ALJ's directions in the Notice of Hearing.[60] The ALJ, via letter, directed St. Camillus to send a copy of the hearing request to the beneficiary and gave St. Camillus 60 days to submit proof that it had sent a copy of the request to the beneficiary and stated that the ALJ could dismiss the request if proof was not provided within that time period.[61] In response to the ALJ's instructions, St. Camillus issued a letter to the ALJ, providing a copy to the beneficiary, which stated that the hearing was made at the beneficiary's request.[62] Although the Appeals Council acknowledged that the response letter included an enclosure, the Appeals Council could not ascertain what was enclosed and whether the request for hearing was enclosed such that the appellant complied with the ALJ's instructions.[63] The Appeals Council found that the dismissal was an appropriate discretionary action within the scope of the regulations when the appellant did not furnish proof of compliance with the requirements of 42 CFR 405.1014(b)(2) despite an opportunity to cure from the ALJ.[64] The case is instructive because it shows the MAC may dismiss cases for failure to comply with the technical requirements of the Notice to Beneficiary of ALJ Hearing requirements.

Additional cases are illustrative of the previously mentioned trends in Appeals Council cases. The first is the case of *Laurence of Oakland*.[65] Laurence of Oakland appealed three Orders of Dismissal issued by an ALJ on grounds that Laurence failed to perfect its hearing

[59] *In the case of St. Camillus Health & Rehabilitation Center*; Docket Number M-13-1380.
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *In the case of Laurence of Oakland*; Docket Number M-13-3799

requests by failing to comply with an ALJ's directions contained in the Notice of Hearing.[66] The ALJ directed Laurence to send a copy of the hearing request to the beneficiaries. It also stated and that Laurence had 60 days to submit proof that it had sent copies of the requests to the beneficiaries and that the ALJ could dismiss the requests if the proof was not provided within that time period.[67] In response to the ALJ's instructions, Laurence faxed to the ALJ a copy of "Attachment A" to the ALJ's instructions; a copy of a spreadsheet identifying the beneficiaries, the HICNs, dates of service, ALJ appeal numbers and the dates the ALJ received the request for hearing; and copies of the certified mail receipts addressed to each of the beneficiaries listed in the spreadsheet.[68] The ALJ dismissed the appeals finding that the appellant did not show that it sent a copy of the actual request for hearing to the beneficiaries. The MAC upheld the dismissal holding (1) that the appellant failed to perfect its request for hearing by not providing the beneficiaries with the requests for hearing which explain the bases for the appeal, and (2) that the appellant failed to furnish proof of compliance with 42 CFR 405.1014(b)(2) despite the opportunity to cure.[69]

The next illustrative case is *Oakwood Hospital and Medical Center*.[70] Oakwood Hospital and Medical Center appealed an Order of Dismissal issued by an ALJ pursuant to 42 CFR 405.1052(a)(3) on grounds that Oakwood failed to perfect its hearing request by failing to comply with an ALJ's directions contained in the Notice of Hearing.[71] The ALJ directed Oakwood to send a copy of the hearing request to the other parties who received the notice of the reconsideration decision (i.e., the beneficiary), and also gave Oakwood 60 days to submit proof

[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *In the case of Oakwood Hospital and Medical Center*; Docket Number M-13-1778
[71] *Id.*

that it had sent a copy of the request to the beneficiary. It also stated that the ALJ could dismiss the request if the proof was not provided within that time period.[72] In response to the ALJ's instructions, Oakwood submitted to the beneficiary and to the ALJ a generic "dear beneficiary" letter that did not identify the beneficiary by name or designate an address where the letter was sent.[73] The letter did not contain any indication that the request for hearing was enclosed with the letter.[74] The MAC upheld the ALJ's dismissal finding that the appellant failed to prove that it notified the beneficiary of the request for hearing.[75] The MAC agreed with the ALJ that the letter was insufficient proof of compliance because it did not list the beneficiary's name or address, coupled with the fact that no other evidence such as a certified mail receipt, delivery confirmation or tracking information was provided to the ALJ to prove that the letter was actually mailed to the correct beneficiary and address.[76] The MAC also noted that the record was devoid of any evidence that the hearing request itself was sent to the beneficiary such that the beneficiary "is informed of the arguments and assertions made by the appellant."[77]

The case of *Presbyterian Medical Center* ("Presbyterian") is also illustrative of the aforementioned trends.[78] In this case, Presbyterian appealed three orders of dismissal issued by an ALJ pursuant to 42 CFR 405.1052(a)(3) on grounds that Presbyterian failed to perfect its hearing request by failing to comply with an ALJ's directions issued in response to Presbyterian's requests for hearing.[79] Notably, the appellant failed to provide the ALJ with signed certified mail receipts, copies of the delivery confirmation tickets or a statement with the name and address of the beneficiary showing the date in which the beneficiary was sent a copy

[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *In the case of Presbyterian Medical Center; Docket Number M-13-1937.*
[79] *Id.*

of the appeal. Although the ALJ found that the beneficiaries were sufficiently identified by the generic letter and enclosed decision, the ALJ concluded that the appellant failed to demonstrate proof of compliance with the ALJ's instructions because the letter did not reflect the beneficiaries' addresses.[80] The MAC agreed with Presbyterian, noting that proof of delivery is not required; however, the MAC upheld the ALJ's dismissals finding that the appellant failed to prove that it sent a copy of the requests for hearing to the beneficiaries. Further, the MAC upheld the dismissal on grounds that even if the generic letter was sent to the beneficiaries, there was no proof that the request for hearing was enclosed with the general letter, in violation of 405.1014(b)(2).[81]

Virtua West Jersey Hospital – Voorhees is a case in which the Appeals Council upheld an ALJ's decision to dismiss on the basis of "abandonment." Pursuant to 42 C.F.R. §405.1052(a)(7), an ALJ may dismiss an appellant's request for hearing if "[t]he appellant abandons the request for hearing. An ALJ may conclude that an appellant has abandoned a request for hearing when the ALJ hearing office attempts to schedule a hearing and is unable to contact the appellant after making reasonable efforts to do so." [82] Abandonment, as described in *Virtua*, includes an appellant's "fail[ure] to demonstrate compliance with Medicare appeals regulations following a request by an ALJ."[83] Virtua West Jersey Hospital ("Virtua") appealed two orders of dismissal issued by an ALJ on grounds that Virtua failed to perfect its hearing request by failing to comply with an ALJ's directions issued in response to Virtua's requests for hearing.[84] The MAC upheld the ALJ's dismissals finding that the Virtua failed to respond the ALJ's requests to demonstrate

[80] *Id.*
[81] *Id.*
[82] *In the case of Virtua West Jersey Hospital - Voorhees; Docket Number M-13-1424 (March 29, 2013).*
[83] *Id.*
[84] *Id.*

compliance with 42 CFR 405.1014(b)(2).[85] On appeal, Virtua claimed that it notified the beneficiaries of the requests for hearing, sent a copy of the request to each beneficiary and sent "a copy" to the ALJ to prove that the beneficiaries were notified of the appeal.[86] Despite Virtua's contentions, the MAC found that the administrative record contained no evidence that Virtua ever responded to the ALJ's letters or actually sent the requests for hearing or any other notice to the beneficiaries.[87]

As is shown by the preceding cases, except for cases where the circumstances were extenuating and where the appellant received conflicting verbal orders, such as *Mat-Su*, strict compliance with the Notice of ALJ Hearing to beneficiaries is required and the MAC will uphold ALJ dismissals where appellants have not shown compliance with the law. In an effort to avoid such dismissals, appellants and their counsel should seek strict and definite guidelines from the ALJ and fully comply with the applicable rules and regulations.

[85] *Id.*
[86] *Id.*
[87] *Id.*