HANDLING MEDICARE ADMINISTRATIVE HEARINGS

PI-YI MAYO, ATTORNEY
BAYTOWN, TEXAS

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I. Introduction

This article is intended to provide the Elderlaw Attorney who has little or no experience with handling a Medicare appeal before an Administrative Law Judge (ALJ) with the tools necessary to undertake such representation. NAELA has devoted great effort to help its members develop and expand their practices into new areas as the field matures. The need for advocacy on behalf of our clients who are in the Medicare system offers great potential for many of us both in terms of meeting the continually changing needs of our clients as well as advancing our legal skills and knowledge.

The recent changes in the Medicare system have been drastic and far reaching. The creation of Part C and the efforts to push Medicare into the HMO realm has, for the first time since the creation of the Medicare system, pitted our vulnerable and ailing clients against a corporate entity whose ultimate goal is to reduce costs and to make a profit from the delivery of their healthcare. This is a legitimate goal of such a corporate entity. The HMO concept is to manage cost in the delivery of services. Unfortunately, one of the ways to manage the cost is to seek to curtail utilization of the services by the beneficiaries. If the corporate entity is the decision maker about what services are necessary, and therefore, what care will be covered by Medicare, then our clients must be able to challenge these decisions in a meaningful manner. In order to be successful in asserting their rights to receive the benefits they are entitled to under the Medicare system, it will become increasingly important that Elderlaw Attorneys provide the advocacy necessary to fight unjustified denials of care.

The need for advocacy on behalf of Medicare recipients has been made clear by the debacle caused by the changes in the home health care component of Medicare. Huge numbers of homebound and ill elderly folks have unjustly, and in some cases, illegally had their care reduced or terminated. The need for advocacy on behalf of these clients and others will continue to grow. In the past, legal services groups have provided the main force of advocates willing and able to take on these types of cases. They can no longer provide the necessary services as the number of people on Medicare grows to 40 or 50 million persons. The private bar must step forward and provide these needed services. In the past, many times a discussion of handling medicare cases began and ended with the question: how can a private attorney make a living doing this type of work? It is hoped that this paper will provide an answer to that question and the background necessary to enable Elderlaw Attorneys to provide the necessary representation that our elder clients will need now and in the future.

An effort has been made to research sources of information other than the publications of the Center for Medicare Advocacy and the many articles already published by NAELA members concerning Medicare issues in other symposiums and institutes. Any knowledge possessed by the author is a direct result of the publications and conversations with the staff of the Center for Medicare Advocacy as well as the teachings of other fellow NAELA

members. This article assumes that any attorney attempting to represent a client in a Medicare appeal will purchase the materials available from the Center. To forego the knowledge and expertise afforded by the many years of handling such appeals would be foolhardy.

II. THE LAW

The Medicare Act is divided into two separate benefit programs: Part A 42 U.S.C. § 1395c-1395i and Part B 42 U.S.C. § 1395 j-1395w. In this paper there are many references to the Social Security Administration (SSA) because almost everything concerning appeals of Medicare (Title XVIII) claims at the ALJ level is controlled by Title II (Social Security) statutes, regulations, and case law. [1] When you see a reference to 20 C.F.R. §404 et.seq., it is most likely a section that is concerning the procedural aspects of an appeal under the Social Security System such as an appeal of a denial of Social Security disability benefits (SSD). The majority of the statutes, regulations and case law that will be referenced in this article is exactly that: law that has been developed by Congress and the courts to deal with SSD claims. Once a case has gone from the reconsideration or carrier fair hearing stage to the ALJ level, it is handled by the same ALJs and bureaucracy that handles SSD matters. This is both a blessing and a curse. The blessing comes from the fact that, except for the specific laws concerning the eligibility for a benefit, all of the procedural aspects of Medicare appeals are exactly the same as those for SSD appeals. The reason that this is such a plus is that there are tons of books and legal publications on how to handle SSD appeals. If your office handles many of these matters, it would behoove you to join the National Organization of Social Security Claimant's Representatives (NOSSCR). They have many different resources available to assist in these types of cases. The curse of this situation is that the system for handling SSD appeals is tremendously overloaded, and any type of action from the time frame for obtaining an appeal date to just getting someone to answer the phone can be unbelievably long.

The statute telling us that all of the procedural laws dealing with SSD appeals apply to Medicare appeals (at the ALJ level and beyond) is located at 42 U.S.C.A. § 1395ii entitled Application of Certain Provisions of Subchapter II. The formal name for subchapter II is TITLE 42 THE PUBLIC HEALTH AND WELFARE CHAPTER 7 SOCIAL SECURITY SUBCHAPTER II - FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS. This statute essentially says that the provisions of §405 and §406 of the Social Security law apply to Medicare as well. References in this article and the statutes to the "Secretary" refers to Secretary of the Department of Health and Human Services.

III. THE HEARING

A. Introduction

Most Medicare appeals are decided based on the medical records and written

statements of the patient's treating physician and other health care providers. [2] Edward Dale, a well known NAELA member and Director of Elder Law and Legal Assistance to Medicare Patients, has written several articles for NAELA over the past years concerning Medicare issues and related advocacy. He has boiled the many factors involved in a decision to file an appeal down to three maxims:[3]

1. The "treating physician rule" which basically means that the physicians who have been involved with the patient for some period of time and have treated him or her are in the best position to know what type of care the patient needs. Their opinion is entitled to deference and absent clear evidence that the opinion of the treating physician is medically unsupported, it should carry the day. This "treating physician rule" is the subject of an unbelievable amount of discussion and explanation in any book or instructional material on SSD appeals. Whole forests have been sacrificed to provide the paper for the materials on this topic in SSD cases. The treating physician rule is not followed to a large extent by HCFA and its contractors at the lower levels of the decision making process. The informal guidelines and cost containment procedures result in denials of care that are based on factors other than the opinion of the treating physician. Obviously, the patient would not have sought the treatment unless the doctor thought it was necessary. In traditional Medicare appeals this was of great importance to the case because the physician was, clearly in most cases, an independent voice with the welfare of the client foremost in mind. The casual observer of the changes taking place in the dynamics between a doctor and patient in the HMO setting would be concerned about this most important part of the appeal. The doctor in the HMO setting is under contract to the HMO that has denied the treatment in the first place. The media has been flooded with stories of doctors who are fighting HMO's to obtain coverage of medical procedures they deem medically necessary but have been overruled by the bureaucrats at the HMO. There are other examples of doctors who fall in line with the treatment plans that the HMO deems appropriate and refrain from prescribing treatment that they know the HMO will not approve.

   The HMO case could present a different scenario. The advocate should find out if the treatment at issue is necessary in the doctor's opinion, and many times this will lead to evidence of great effort on the doctor's part to obtain approval of the care by the HMO. The author has interviewed many

doctors who are terribly frustrated and very indignant that their treatment decisions are questioned by the HMO. Many physicians have staff members who spend all of their time calling HMO's trying to obtain approval of a particular course of treatment or test. The frustration that doctors feel with being second guessed by the HMO could be a fertile ground for the type of evidence that can assure success at the appeal.

The case should be appealed if there is evidence that the treating physician believes that the care is medically necessary.

2. If the case presents an issue of doubt as to whether a particular treatment should be covered, then the case should be appealed. In baseball parlance, a tie goes to the runner and our clients are the runners. In order to allow medicare recipient to receive the health care that congress intended, the courts have consistently held that the medicare act should be liberally construed and read broadly. Those of us with good memories may remember the cases we studied in law school concerning "remedial statutes", which is basically the same idea in Medicare cases. Remedial statutes are always liberally construed. Black's Law Dictionary gives as part of the definition of liberal construction, "It resolves all reasonable doubts in favor of the applicability of the statute to the particular case." Hence, if the case is not strictly lost on the law pertaining to the coverage issue, it should be appealed.

3. If the decision to deny the coverage is based on a policy or "rule of thumb" set forth in the carrier manual or policy of the HMO and not on Medicare law or regulation, then it should be appealed. The Medicare world abounds with often repeated bromides that have become the hard and fast rules by which decisions concerning treatment are actually made. It is very easy to discover the control these bromides have on the overall Medicare coverage issue. One of the more infamous ones deals with the idea that Medicare will not cover care that is not "restorative." In order to investigate this well know "fact" about coverage one need only go down to a doctor's office that treats many Medicare patients and inquire. In every such office there is always a nurse or office manager who has the main responsibility for billing Medicare for the services provided. Find that person and ask them; they will readily tell you that Medicare will not cover such care. Now, before you discount

the opinion of such a person on the issue it must be remembered that this person is the "expert" in the office who makes decisions based on his or her experience with past denials of coverage. Lack of restorative potential in not a basis for a denial of care that is supported in the regulations or the law.[4] The Medicare law provides for coverage if the care prevents or slows deterioration of the patient's condition or maintains the present level of functioning. 42 C.F.R. §§409.32(c), 409.44(c)(iii).

If you cannot find the basis for denial in the actual law or regulation, then it is likely a denial decision made on some other criteria and will not prevail upon appeal. In the ALJ hearing the Judge will apply the law and regulations to the case.

B. Day in Court

1. **Jurisdiction.** The administrative hearing before the Secretary is the heart of any Social Security claim, and consequently, the heart of its twin the Medicare appeal. [5] This is the only time that your client will get a "day in Court." It is the only chance to present live testimony, to cross examine witnesses and to object to the admission of evidence. The preparation for the hearing should be carried out with the same attention to detail that the advocate would use in any civil lawsuit. The administrative hearings are controlled by the Administrative Procedure Act and the applicable provisions of the Social Security Act. Under the Social Security Act, the Secretary is authorized to promulgate rules and regulations concerning the conduct of such hearings. [6] Once a request for a hearing is filed, the jurisdiction of the case passes to an administrative law judge (ALJ). An ALJ is an employee of the Office of Hearings and Appeals (OHA), one of the major components of the Social Security Administration. The OHA derives its authority to hold hearings and render decisions in connection with administrative appeals from reconsideration determinations in title II (Old-Age, Survivors, and Disability Insurance) and Part A and B of title XVIII (Medicare) of the Social Security Act by direct delegation from the Secretary of Health and Human Services. [7] The ALJ has jurisdiction to hear appeals from reconsideration determinations involving entitlement to benefits such as insured status or enrollment, under Part A or B, or the termination of such entitlements if the

amount in controversy for the Part A claim is $100.00 or more, and for Part B if the amount in controversy is $500.00 or more. [8] The ALJ also has jurisdiction to determine if the benefits in controversy are over the required amount. The ALJ does not have jurisdiction to review national coverage determinations respecting whether a particular service or item is covered by Medicare. The ALJ in reaching his decision will consider the case file as prepared by the Carrier or Intermediary and any additional documentation or evidence presented at the hearing by the claimant or witnesses. The ALJ's decision must be made under the applicable provisions of the law and regulations governing the claim. Once the ALJ renders a decision the claimant is notified in writing and a copy of the decision is placed in the case file. If the ALJ has reversed the decision of the Intermediary, the file is then reviewed by the Appeals Council for an "own motion" review by the Appeals Council. Upon expiration of the time allowed for an appeal and completion of the review of the Appeals Council, the file is forwarded to the HCFA regional office which then notifies the Intermediary to take the proper action to effectuate the ALJ's decision. A decision of an ALJ is not a precedent opinion. However, significant decisions of ALJs may be published as HCFA Rulings. These rulings can be applicable to other cases with similar facts and must be followed by Intermediaries.

2. **Role of Administrative Law Judge.** The ALJ hearing is a *de novo,* hearing and a hearing before an ALJ in both SSD and Medicare appeals is a non-adversarial proceeding. [9] This is the part that can make handling such appeals fun. In most other types of hearings concerning a regulatory agency's decision, the agency will be represented by counsel. This is not the case in an appeal from a denial of Medicare benefits. There is no "opposing counsel" in the classic sense. There are no depositions to take, no interrogatories to respond to and no motions to argue. The presence of attorneys on both sides of an issue is intended to assure proper development of the law and issues. Since this is not the case in a Medicare appeal, the ALJ is responsible to make sure the record is adequately developed.

C. Procedure

1. **Request for Hearing.** A request for hearing must be in writing and filed at the office of the Social Security

Administration or the Health Care Financing Administration. A request can also be filed with the Intermediary who rendered the reconsideration as well. [10] You can obtain a form from the Social Security Office, or a letter will suffice. The time limit for filing an appeal is 60 days from the date of receipt of the reconsideration notice. The actual limit is 65 days allowing 5 days for mail delivery. In the event the time limit is missed, an extension can be granted for "good cause."[11] The reason given for establishing "good cause" can include such things as (1) you were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person; (2) There was a death or serious illness in your immediate family; (3) Important records were destroyed or damaged by fire or other accidental cause; (4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods; (5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit; (6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit; (7) You did not receive notice of the determination or decision; (8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired; (9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.[12]

2. **Setting** . The setting for a hearing can be anything from a full-blown courtroom with all the trappings to a rented space in a hotel. Many areas do not have spaces for these type hearings and use the courtroom of the local bankruptcy court; or, if a visiting judge is conducting the hearing, it may be held in the hotel where the judge is staying. Most will be held in a room with a conference table with the judge sitting at on end of the table. A clerk will be recording the hearing and in some cases there will be a medical expert present. It is important to know these details because if you are going to present the testimony of your client or some other witness, you should explain the physical layout of the hearing room to your witness so that they

will feel at ease when they enter the room. The hearing is closed to the public, but most judges, with the consent of the applicant, will allow observers that have a reason for attending. preparation with your witness, you must keep this in mind and not depend on an opportunity to discuss at length any issues of importance at the site of the hearing.

Often clients in such an appeal will not be able to drive themselves to the hearing. A family member or relative will most often provide the transportation to the hearing. Never underestimate the importance of making sure your client/witness has adequate transportation to the hearing and that the people providing such transportation have a map or knowledge of the area so that they are able to find the location. There are many software programs on the market that will allow you to create a map from the client's home to the hearing site if you have the client's address. As a backup, make sure the client has your office number and that you have a staff member that can give directions to the location if the client should become lost on the day of the hearing.

3. **Evidence.** The ALJ makes his decision on the basis of the evidence contained in the file as prepared by the Intermediary or Carrier, any additional evidence the claimant presents, evidence that is otherwise submitted, and any testimony given at the hearing.[13] The Intermediary or Carrier is instructed to include specific documents in the file that is sent to the ALJ. The list of documents that is to be sent by a Carrier includes the following:

a. The Medicare claim form with the relevant attachments or facsimile showing the original payment date.

b. A copy of the Explanation of Medicare Benefits (EOMB) or facsimile showing the original payment date.

c. Any documentation relating to your reopening. Prepare separate exhibits for each.

d. The Request for Review form (HCFA-1964) or letter with all attachments.

e. Any other pertinent documents.

f. Opinions of medical consultants or other experts who have provided advice (e.g., RN, staff physician). If your hearing officers rely on physicians or other third-party experts, including your staff physicians and medical consultants, and refers to their reports, statements, or opinions in the decision, assure that the statements are in writing, signed by the expert and included in the file. Include the professional qualifications of experts on whose opinion the decision is based.

g. A copy of your review determination.

h. The original carrier hearing request.

i. An Appointment of Representative Form (HCFA-1696) or other authorization forms.

j. Medical information considered by your Hearing Officer including treatment notes/summaries, physician's certification of medical necessity, doctor's orders/progress notes.

k. Your policy guidelines followed in the case that are available to the public.

l. Applicable sections of the law, regulations, and the Medicare Carriers Manual, unless your decisions provide these references.

m. A copy of the dated hearing decision.

n. If the fair hearing was taped, a copy of the tape. If the tape is not available, include a written explanation. Adequately identify the tape for re-association with the file. If a transcript was prepared, include it.

o. Original request for ALJ hearing. This must be signed by the claimant or an authorized representative. Implied requests or hearing decisions with the words "ALJ hearing" circled are unacceptable. If there is any documentation of good cause for late filing of the request for ALJ hearing, place it on top of the request.

p. New evidence provided with the ALJ hearing request.[14]

The advocate should review the list of items and make sure that these items are in the file. Items J and I should be carefully scrutinized to make to determine the basis for the denial.

4. **Subpoenas.** The ALJ has the authority to issue subpoenas requiring the attendance and testimony of witnesses and the

production of any evidence that relates to the issues involved in the hearing. [15] Experience in SSD cases shows that ALJ's are reluctant to issue subpoenas, particularly when the subpoena will be addressed to a doctor. A request for a subpoena must be filed at least 5 days prior to the hearing date and must give the names of the witness or document to be produced and describe the location of the witness or document with sufficient detail to find them. The request must state the important facts that the witness or document is expected to prove and indicate why these facts cannot be proven without the aid of a subpoena. The SSA will pay the cost of issuing the subpoena and the fees and mileage of the witness.

5. **Responsibilities of Claimant's Counsel.** You have requested the hearing and the day has come. What do you do now?

   a. Get to know your ALJ. As related above the ALJs hearing Medicare appeals are the same ALJs that handle SSD and SSI cases. Contact attorneys who handle SSD Appeals and obtain information regarding the ALJ in front of whom you will be appearing. In most areas, the members of the Social Security Bar will even have a local group that will have regular meetings. Most of the meetings that the author has attended focus on the law, but considerable amount of discussion is had concerning the ALJs and their different personal styles and what arguments and evidence may be more persuasive to one ALJ and less so to another. Do not be disheartened if your ALJ has a reputation for being tough on SSD applicants though, because your claim for Medicare is somewhat different than a claim for SSD benefits.

   b. Marshall your evidence. Reviewing the file prepared by the Intermediary or Carrier is one of the most important things you should do. This may be your greatest role as advocate for the claimant. It doesn't matter how much time has passed since it was sent in, nor does it matter how many certified mail green cards you can produce. Many times, the evidence you are relying on will not make it to the file. Always

have copies of the evidence that is most important to your case in hand when you appear for the hearing. If the records are missing, you can hand them to the judge during the hearing. Always have your transmittal letter and green card handy to show that you have previously sent the records in, as many ALJ's will be irritated with you if you could have submitted the evidence in advance of the hearing and neglected to do so.

Obtaining records from doctors and hospitals takes lots of time. Unfortunately, even after a written request is made to the doctor's office, it may take a follow up phone call or an offer to pick them up to prod the medical entity to finally produce the records. Never delay in ordering the necessary records once you have taken on the case.

Almost any kind of evidence is admissible in a proceeding under the SSA. [16] The only test of admissibility is relevancy and materiality. Any doubt with respect to the admissibility will usually be resolved in favor of the proponent. Unsworn medical records, letters from employers or friends are normally always admitted without a problem. Likewise, testimony of witnesses, such as bosses, or spouses will be admitted.

c. <u>Prepare a written Summary</u>. If the records are voluminous, then prepare a "Claimant's Summary of Exhibits in Support of Claim." In such a document, set forth the actual components of the Medicare law you are claiming benefits under and the exhibit number and page of the record that supplies each element of the proof for that particular item of the law. This can be extremely important in the event that a medical expert will be testifying at the hearing.

d. <u>Dealing with testifying experts</u>. This testifying expert will more than likely be a retired physician. The expert is supposed to receive a copy of all of the medical records and other evidence in the file for review prior to the time of his or her testimony. As set forth above, many times crucial medical

documents will not make it to the file and will have to be provided to the ALJ at the hearing. Therefore, it is impossible for the testifying expert to have the benefit of the medical records prior to the hearing. We all know that it is human nature not to want to admit our mistakes, particularly if we are an "expert" and our opinions or mistakes are being recorded for later examination. Add to that problem that very few of us are skilled enough in medical procedures and terminology to take on a doctor head to head in a cross examination and prove how he or she is wrong based on the medical records. Also, remember that even if you do pin the doctor's ears down with some brilliant questioning, you still might not get anywhere because they can still simply say that it is their "opinion" no matter how ludicrous it may sound. It makes much more sense and it has been my experience that the thing to do is to prevent the doctor from making a mistake in the first place. If you prepare a good "summary" that shows the exhibits and how they support each element of your case, then you may have prevented a need to have that brilliant cross examination. Many times the doctors who are testifying at the hearing have not poured over the records in the file, particularly if there are many pages of records to digest. If the testifying expert is given a copy of your summary in advance of their testimony, it may call to their attention an exhibit or finding that they had not previously noticed. At the very least, it will put them on notice that they will be cross-examined about each of the records in the summary, and if they have not been diligent in their review of the records it will be apparent. Many times this opportunity to consider these factors will be of great assistance to the medical expert in presenting his or her testimony.

e. Prepare your open and close. Always prepare an opening statement, and if the issues are such that it would be helpful (and in most cases it will), prepare a written memorandum setting forth the law and the legal authority in support of your position for the ALJ's perusal. Remember, the decision made by the Intermediary will in all probability not be one that will

apply the evidence to the Medicare Act. The value of presenting the law and the facts of your case in a logical manner in writing cannot be overstated. In writing the memo, demonstrate for the ALJ an outline for the Judge's decision.
If the ALJ allows you to make a closing, then make sure that you cover any issues that have come to your attention during the hearing that were not covered in your memo or opening statement.

f. Keep the record open. Further, if some new issue has arisen during the hearing, you should ask the ALJ to "keep the record open" to allow you a chance to get additional evidence into the record to address the new issue or to meet any gaps in the record you perceive have been highlighted by the testimony or questions of the ALJ. This is another example of why this is such a great area to practice. How many other types of cases do you handle, where if you find that you have missed something or learn after the fact that you could have done something differently, you get a second chance to correct the oversight. If you hold the record open then you can submit new evidence and, if necessary, submit an additional memorandum for the ALJ to consider. [17]

IV. ATTORNEY FEES

We must start a discussion of attorney's fees with the admonition that when in doubt as to how something will be done or what law applies in Medicare appeals, return to the law, rules and regulations governing Title II cases (regular Social Security). [18] There are several different sources for obtaining payment of attorney's fees in Medicare cases: the fee petition process, the fee agreement process and the Equal Access to Justice Act (EAJA). Since the EAJA only applies to fees payable for work performed before a court in an appeal of an ALJ or Appeals Council's decision, it will not be discussed in this paper. [19] It is important to note that if a claim is pursued from ALJ to District Court, then the attorney must petition the forum before whom the services were provided for an allowance of fees for the time and effort expended in each proceeding and obtain approval from either the Secretary or the court for those fees. [20]

A. Regulation of Fees by SSA.

All fees that an attorney charges in connection with the representation of a client in a Medicare appeal before an ALJ are very stringently

controlled by statute. **No fee may be charged for representing a claimant in a hearing before an ALJ unless the amount of the fee is approved by the Secretary.** [21] It has been advocated by many experienced practitioners that if the fee is paid by someone other than the claimant then the restrictions do not apply. An example of such a case would be a family member or friend who agrees to pay a fee for the work of the attorney on behalf of the claimant. At least one commentator has opined that any fee even if paid by a third party must be approved by the Secretary. [22] This has been a method that has been used by attorneys in the past and has been explained to the author as a means of avoiding the difficult and painstaking task of obtaining approval of a fee under the statutory requirements. In Medicare cases recovery of payment for medical expenses often results in additional monies being paid by a Medigap policy to the claimant. It has been suggested that the statutory limits on recovery of fees does not apply to the monies recovered from a Medigap policy. [23] Research has not produced any cases on point, but it appears that the regulations and the statute would make such a position tenuous at best. 20 C.F.R. § 404.1720 Fee for a representative's services appears to speak directly to the issue of the payment of a fee by third party benefactor:

> (a) General.
>
> A representative may charge and receive a fee for his or her services as a representative only as provided in paragraph (b) of this section.
>
> (b) Charging and receiving a fee.
>
> (1) The representative must file a written request with us before he or she may charge or receive a fee for his or her services.
>
> (2) We decide the amount of the fee, if any, a representative may charge or receive.
>
> (3) A representative shall not charge or receive any fee unless we have approved it, and he or she shall not charge or receive any fee that is more than the amount we approve. *This rule applies whether the fee is charged to or received from you or from someone else.* (emphasis added)

It can be argued that the regulations possibly cover the charging of a fee based on the recovery from the medigap policy because of the

expansive definition that the regulations use to define what "services" the regulations control. 20 C.F.R.§ 404.1735 Services in a proceeding under title II of the Act:

> Services provided a claimant in any dealing with us under title II of the Act consist of services performed for that claimant in connection with any claim he or she may have before the Commissioner of Social Security under title II of the Act. *These services include any in connection with any asserted right a claimant may have* calling for an initial or reconsidered determination by us, and a decision or action by an administrative law judge or by the Appeals Council. (emphasis added)

20 C.F.R. § 404.1740 Rules governing representatives at section (b) seems to expand the reach of the regulations even farther concerning what fees are covered by the rules. It states that a representative may not-

> (b) Knowingly charge or collect, or make any agreement to charge or collect, *directly or indirectly,* any fee in any amount in excess of that allowed by us or by the court. (emphasis added)

As previously stated, no cases have been found that speak directly to the application of these regulations to fees charge to and paid by 3rd parties on behalf of the claimant or to the charging of fees for recovery of the medigap proceeds but at the very least these regulations should be considered when deciding how to charge for your services.

B. Fee Petition

1. **General Description.** Prior to the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, § 5106, was the only way to obtain approval of a fee in an administrative proceeding before the Secretary was the "fee petition process." The fee petition process has been described as "cumbersome" by some commentators, but most attorneys experienced with the process would say that is a kind description. [24] The overwhelming majority of attorneys with experience in handling SSD cases do not use the fee petition process; they avail themselves of the expedited fee process describe below. The reason so many SSD attorneys do not use the fee petition process is highlighted by the name given the "new process"; it is called the "expedited process". Under the old system, the fee petition process, inordinate delays occurred in both the authorization of fees and in the actual payment of the fees authorized. [25] Under the fee

petition process, it takes a long time after the completion of the hearing to obtain payment. There are other factors that should be considered in selecting the method for payment. One such factor is the amount of benefits to be awarded to the client if the case is successful. Another requirement of the fee petition process is that in order to obtain an award, it is necessary to keep time records. Although the fee petition process allows for a fee agreement to be based on a contingency basis, this premise is illusionary. If it is your desire to base your fees on a contingency basis the fee petition process is probably not the most desirable. In the context of SSD cases, it has been suggested that the fee petition process only be used in cases when either small or no recovery of back benefits is expected or in cases that it are expected to require many hours of attorney time. [26] This is one specific instance when the experience of the SSD bar may not translate well to handling appeals of Medicare cases. The differences in the recovery of a claimant and the work involved in handling a Medicare appeal may tend to support the use of the fee petition process in Medicare cases as opposed to SSD claims.

2. **Direct payment of fee and 25% limit.** The fee petition process allows the attorney to use any method of calculating a fee. Further, in spite of the oft repeated bromide that attorney fees are limited to 25% of the past-due benefits, this is not the case in matters before the Secretary. There is such a limit when requesting fees for work before a federal court. [27] There is some confusion caused by the statute and the regulations that leads to the belief by many that the 25% limit applies to ALJ proceedings as well. The source of the confusion is that the SSA will not <u>withhold</u> more than 25 % of past due benefits for direct payment to an attorney. This does not mean that the SSA will not <u>approve</u> a fee charging more than 25% of the past due benefits. It requires a careful study of the regulations to confirm this position. The main regulation concerning the fee an attorney may charge is 20 C.F.R. § 404.1725 entitled <u>Request for approval of a fee</u>. This regulation describes the rules that must be followed in obtaining authorization to collect a fee in an ALJ proceeding. There is no mention in this part of the regulations of <u>any limit on a fee amount</u>. As set forth above, 20 C.F.R. § 404.1720 <u>Fee for a representative's services</u> requires that any fee charged by a representative must be approved by SSA but does not contain any limit on the amount of the fee charged. The only limit on fees is found in 20 C.F.R. § 404.1730(b)(1) and that section only speaks to the amount of money the SSA <u>will withhold from past-due benefits</u> and pay directly to an attorney. Thus, if a fee in excess of 25% of past-due benefits is authorized by the SSA, that part of the fee over the 25% of past-due benefits will have to be collected from the client.[28]
3. **Contingent or hourly basis.** The rules for submitting a fee request are found at 20 C.F.R. § 404.1725 entitled <u>Request for approval of a fee.</u>

However, a template for correctly filing a request for a fee exists in a form that can be obtained from SSA known as "Petition to Obtain Approval of a Fee for Representing a Claimant Before Social Security Administration". A copy of the form is attached as Exhibit C. The proper groundwork must be laid prior to the submission of such a petition. Upon taking on the matter, a written fee agreement should be obtained and signed by the client. Most Social Security cases are handled on a contingent fee basis because few disabled clients have the money to pay an hourly fee for the work. If a contingent fee is contemplated and the client does have the resources to pay, there is an ethical obligation to offer the client an alternative fee arrangement before accepting the matter on a contingency basis. [29] The question of whether to handle a Medicare appeal on a contingent or hourly basis is somewhat related to the following discussion concerning the "expedited fee process." but it may be helpful to discuss several factors at this point. Most of the time, these types of cases will be handled on a high volume, low fee basis. The majority of the work will be repetitive in nature and should be handled by staff with streamlined office systems. The process of gathering the necessary information and records should be a routine, and in most cases, repetitive task. The Center for Medicare Advocacy has a wealth of excellent materials to assist in setting up the office systems required to process the paperwork for such an appeal. The reason many of attorneys like contingency fee agreements is because they do not have to keep scrupulous time records. That is not the case in these matters, even if your fee is based on a contingency. It must be remembered that you are free to base your agreement with your client on any basis but that fee must ultimately be approved by the Secretary. The SSA in evaluating a fee sets forth many factors that they will consider in the regulations. [30] The regs do not base the decision to evaluate a contingent fee on the traditional factors as found in the ABA Model Rules of Professional Conduct. These factors include such things as the experience, reputation and ability of the lawyer involved, the prevailing market rate and the actual percentage approach to the calculation of the fee. The SSA bases its decision on how large a fee to approve primarily on the time spent on a case multiplied by an hourly rate "plucked out of the air as a yardstick to measure a fee request." [31] The effect of the conduct of the SSA is to completely obliterate the nature of a contingent fee agreement as most of us know it. The most important thing to remember after having a fee agreement signed by your client is to keep meticulous time records. In addition to keeping the time spent on the matter, you should also make sure the records reflect the reason for the effort. Explain why you had to call the doctor personally or why you had to spend

extra time preparing a witness because of their particular infirmity.

4. **Preparation and filing the fee petition.** Once the hearing is over, the Petition to Obtain Approval of a Fee for Representing a Claimant Before Social Security should be completed. The form has 3 carbon copies; one copy must be sent to your client and, if possible, you should have your client sign the fee petition. It is not necessary in order to obtain an award but their signature indicating that they have reviewed your request and agree with it will allow the petition to be processed immediately. [32] Once the petition has been completed, it should be filed with the ALJ. The ALJ has the authority to approve fees up to $5000.00. If the request exceeds $5,000.00 and the ALJ thinks you are entitled to more than $5000.00, the ALJ must write a memorandum to the regional office recommending the amount they believe you are entitled to receive. It can be helpful for the advocate to understand the actions that the bureaucracy will undertake to handle a fee petition. In order to understand the process the SSA goes through in handling a fee petition, the HALLEX sections dealing with the approval of a fee petition should be reviewed. [33] (A copy of the pertinent HALLEX sections is attached as Exhibit B.) If the fee request exceeds $5000.00, you should submit a memorandum to the ALJ setting forth the specific reasons that this case required special effort as an aid to the ALJ in writing their memorandum to the regional office. If you are charging your fee on an hourly basis, the petition can be submitted at the end of the hearing process but if your are charging a fee based on a contingency basis, you will have to wait until there is an Award Certificate issued showing the amount of benefits awarded so that you have an award to base the calculation of your fee. In order to have a fee withheld from the past-due benefits and sent directly to the attorney, a notice of an intent to file a request or a fee petition must be filed within 60 days of the date of the notice of a favorable decision. This means that in a contingency matter, although you must wait for a determination of benefits to be made before you can calculate your fee and actually submit your fee petition, you must send a notice of your intention to do so within 60 days or SSA will not withhold the fee from the claimant's benefits. [34]

5. **When to use a fee petition.** Although the fee petition process requires scrupulous timekeeping and is somewhat difficult to navigate, once office procedures are in place to produce the information necessary to complete the fee petition, the process should not be that difficult to master. It is possible that this method of obtaining payment in ALJ appeals will be the best for your office. It holds great attraction when the work required to complete many cases is repetitive and the amount of recovery of benefits varies greatly. In cases with a low recovery, a request for approval based on an hourly rate may produce better results. In these cases the fee request will usually exceed the 25% limit allowed in the expedited fee process described below.

C. Expedited Fee Process

1. **General description.** The expedited fee process was put into effect in 1991 and there have not been any significant changes in the system for authorizing and paying fees in the SSD system since that time hence, the expedited fee process is often called the "new process." It is also referred to as the "fee agreement process", although any method involving the approval of fees by SSA must include the use of a written agreement between the claimant and the advocate. The fee agreement process is much easier to complete and is intended to be much faster than the fee petition process described above. SSD commentators have given it unqualified endorsement over the fee petition process. [35] If the rules of the fee agreement process are followed then the fee must be approved by the Secretary. [36]

2. **Requirements of the fee agreement process.** The requirements of the fee petition process are quite simple. Basically, you must have a signed fee agreement with your client that specifies:

a. that your fee is limited to the lesser 25% of total past-due benefits or $4,000.00;

b. you must submit your fee agreement to the SSA prior to your hearing;

c. you must obtain a favorable decision;

d. the claim must result in past due benefits; and

e. neither the claimant, and auxiliary beneficiary nor a decision maker (the ALJ) objects.

That is all there is to it. As can be gleaned by reviewing the prior discussion on fee petitions, the obvious advantages to the fee agreement process are apparent. One of the reasons that makes it most attractive is that you do not have to keep time records that must be reviewed by the Secretary prior to approval of the fee. Secondly, the

payment of a fee directly to the attorney is much faster than under the fee petition process.

D. Escrow Trust Fund Method

In Medicare cases you can request that your client deposit money with you to be held in a trust account pending approval of your fee by the Secretary. Social Security Ruling 82-39 (a copy is attached as Exhibit A) specifically authorizes such a process in Social Security cases and, although the ruling does not specifically authorize the procedure in Medicare cases, the ruling would be applicable to Medicare cases. [37] This procedure is only available in cases that are handled on an hourly basis, not for contingent fee cases.

E. Non recovery cases

As mentioned previously, there are many misconceptions concerning the restrictions on the approval of fees by the SSA and in turn misconceptions about the ability to collect fees under the statute. The myth that a fee will not be approved if it exceeds 25% of the recovery made on behalf of the claimant has already been dispelled. There is one other largely misunderstood provision concerning the approval of a fee by the SSA. The Secretary must award a reasonable fee to an attorney if the Secretary makes a favorable determination in a claim to compensate the attorney for the services performed in connection with such claim. [38] Many advocates are unaware that it is possible to obtain an approval of a fee even if the case does not result in an award of benefits for the client. This would seem to make sense to most attorneys accustomed to charging fees on an hourly basis as opposed to a contingency basis. In a traditional contingency fee case there is some risk that an unfavorable outcome will result in no fee being earned by the attorney. As a result of the risk involved, the attorney is allowed to share in a favorable outcome such that the fee received will normally exceed what might have been earned on an hourly basis. Even if a contingency fee is the basis of the agreement between the attorney and the client, if the fee petition method is utilized we know that the SSA will still consider the amount of time that the attorney put in the case in determining what fee to approve. However, the regulations that explain the methodology SSA uses for evaluating a fee request explicitly state that an award of fees is possible even if no benefits are payable. 20 C.F.R. 404.1725(b) Evaluating a request for approval of a fee :

> (1) When we evaluate a representative's request for approval of a fee, we consider the purpose of the Social Security program, which is to provide a measure of economic security for the beneficiaries of the program, together with?
> (I) The extent and type of services the representative performed;
> (ii) The complexity of the case;
> (iii) The level of skill and competence required of the representative in giving the services;
> (iv) The amount of time the representative spent on the case;

(v) The results the representative achieved;
(vi) The level of review to which the claim was taken and the level of the review at which the representative became your representative; and
(vii) The amount of fee the representative requests for his or her services, including any amount authorized or requested before, but not including the amount of any expenses he or she incurred.

(2) Although we consider the amount of benefits, if any, that are payable, we do not base the amount of fee we authorize on the amount of the benefit alone, but on a consideration of all the factors listed in this section. The benefits payable in any claim are determined by specific provisions of law and are unrelated to the efforts of the representative. *We may authorize a fee even if no benefits are payable.* (emphasis added)

The ability to obtain approval of a fee without an award of benefits may be very important in the event that the Medicare appeal produces a favorable decision that results in care being provided by an HMO as opposed to a benefit being obtained that represents the payment of money. If for some reason a case was to be a difficult case with little chance for success but the client is adamant about pursuing the appeal absent the ability to obtain approval of the fee even if the appeal was lost, it would be difficult for a client in such a case to obtain counsel. The fact that a fee can be authorized in a case with no recovery may encourage the use of the fee petition process over the fee agreement process in Medicare appeals.

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1. McCormick, Harvey, Medicare and Medicaid Claims and Procedures, 2nd Ed., p.753 West Publishing Co. (1991).

2. Dale, Edward, Medicare Law; Coverage and Appeals, page 26, Connecticut Bar Association training materials, (May 13, 1998).

3. Dale, supra p. 26.

4. Dale , at p.22.

5. McCormick, Harvey, Medicare and Medicaid Claims and Procedures, 2nd Ed., p.720 West Publishing Co. (1991).

6. McCormick, at page 702.

7. Medicare and Medicaid Guide (CCH) 13,530 (1996).

8. 42 U.S.C.A. § 1395 ff (a) and (b) (2) (B).

9. McCormick, at page 752.

10. 42 C.F.R. § 405.722.

11. 20 C.F.R. § 404.933(c).

12. 20 C.F.R. § 404.911

13. McCormick, at page 743.

14. Medicare Carriers Manual

15. 20 C.F.R. § 404.950(d).

16. McCormick, at page 4.

17. HALLEX I-2-720.

18. McCormick, at page 241.

19. 28 U.S.C. § 2412(d)(1)(A).

20. McCormick, at page 251.

21. 42 U.S.C.A. § 406.

22. Martin, Peter, Martin on Social Security, Vol. II §U 000. West Group, (1998).

23. Dale , at p. 50.

24. Bush, Thomas E., Social Security Disability Practice, 2nd Ed., Vol. II at page 7-9. James Publishing, Inc. (1998).

25. McCormick, Harvey, Social Security Claims and Procedures, 4th Ed., p.357 West Publishing Co. (1991).

26. Bush, at page 7-3.

27. 20 C.F.R. § 404.1728(b).

28. Bush, at page 7-9.

29. Bush, at page 7-10.

30. 20 C.F.R. § 404.1725(b).

31. Bush at page 7-11.

32. Bush at page 7-11, 7-12.

33. HALLEX I-1-201 A.2 thru I-1-230.

34. 20 C.F.R. § 404.1730 (c).

35. Bush at page 7-3.

36. 42 U.S.C.A. § 406(a)(2)(A).

37. McCormick, at page 241.

38. 42 U.S.C.A. § 406.

EXHIBIT "A"

SSR No. 82-39

SOCIAL SECURITY ADMINISTRATION
TITLES II AND XVI--USE OF TRUST OR ESCROW ACCOUNTS IN COLLECTION OF ATTORNEY FEES
PPS-68

PURPOSE: To state the policy on the use of trust or escrow accounts in collecting attorney fees for representation before the Social Security Administration (SSA).

CITATIONS (AUTHORITY): Sections 206(a), 207, and 1631(d)(2) of the Social Security Act; Section 413(b) of the Black Lung Benefits Act (part B of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended); Regulations No. 4, sections 404.1720 through 404.1740; Regulations No. 10, sections 410.686b through 410.687a; Regulations No. 16, sections 416.1520 through 416.1540.

PERTINENT HISTORY: Legal organizations and individual attorneys have asked whether the use of trust or escrow accounts as a means of collecting attorney fees in connection with Social Security and black lung claims is consistent with the fee provisions of the law and regulations.

As a condition for undertaking representation, some attorneys solicit from Social Security or black lung claimants a deposit of money in a trust or escrow account as a means of assuring payment of the attorney's fees. The claimant may be asked to place funds into a

trust or escrow account at the commencement of representation on a noncontingency fee basis, or in connection with a contingency fee agreement. In title XVI claims especially, some agreements may call for the claimant to deposit the first benefit check into a trust or escrow account pending approval of a fee by the Social Security Administration. In regard to title II, title XVI, and black lung claims, the law provides that the Secretary may, by "rule and regulations, prescribe the maximum fees which may be charged" for services performed in connection with such claims. and that any agreement violating that rule or regulation would be void. The law also prohibits the charging or collecting of a fee, directly or indirectly, in excess of the maximum fee prescribed by the Secretary.

In certain cases the term "fees which may be charged" could be interpreted to include any amounts exacted by an attorney from a claimant's property, whether by way of a retainer, deposit in a trust or other escrow account, etc. If, however, the exaction is no more than security for the payment of a potential debt, it should not be considered a "fee." For example, a sum deposited under a trust or escrow agreement, which the claimant willingly entered into, could not legally be characterized as a "fee" if the agreement explicitly states that any money in excess of the fee authorized by SSA will be returned to the claimant when SSA approves a fee or when the claimant pays the attorney an amount SSA approves as a fee.

Applicable to title II, title XVI, and black lung benefits, the law provides that: "The right of any person to any future payment under this title shall not be transferable or assignable, at law or in equity . . ." This provision prohibits payment directly by SSA to a transferee or assignee of the claimant or someone else on his or her behalf. However, this provision does not preclude a claimant from using the benefits after receipt, any more than it precludes a claimant from using any other personal property as he or she sees fit. Thus, the placement of a claimant's funds (whether from benefit payments or other sources) into a trust or escrow account prior to and contingent upon SSA's authorization of a fee for the attorney's services is not a transfer or assignment within the meaning of the law.

Beyond these considerations, the fee provisions of the law that apply to title II and black lung claims differ significantly in one respect from the provisions applicable in title XVI claims. In title II and black lung cases, to assure that the claimant's attorney will be paid at least a part of the fee SSA approves, the law requires SSA to directly pay the attorney the authorized fee (up to a statutorily prescribed limit) out of the claimant's past-due benefits. In title XVI claims, there is no such statutory authority which could serve to encourage attorney representation. Thus, establishment of escrow and trust accounts, under agreements willingly entered into, is a mechanism that may encourage representation of claimants in title XVI claims, where otherwise the prospect of attorney representation would not exist.

As noted above, in title II and black lung claims, the law mandates that SSA will directly pay

to an attorney the amount of the authorized fee (up to the prescribed limit) out of the claimant's past-due benefits. In cases where a title II or black lung claimant and his or her attorney have entered into a trust or escrow account agreement, the money deposited in the trust or escrow account may have been paid over to the attorney, in accordance with such agreement, after SSA's award of benefits to the claimant but before direct payment of the authorized fee out of past-due benefits. Were SSA to make direct payment to the attorney out of past-due benefits without taking into account the money paid to the attorney out of the trust or escrow account, it would be highly probable that the attorney would have "collected" a total fee in excess of the fee authorized by SSA, and thus find himself in violation of the fee provisions of the law and regulations. Therefore, while the law mandates direct payment of attorney fees in title II and black lung cases, that mandate need not be construed so rigidly as to force SSA to make a fee payment when it is known that that payment, when added to monies already collected, would place an attorney in violation of the law and SSA's own regulations.

POLICY STATEMENT: Consistent with Social Security law and regulations, an attorney may solicit from Social Security and black lung claimants whom he or she represents before SSA a deposit of money into a trust or escrow account as a means of assuring payment of the fee for services in connection with such representation, provided that:
a. the claimant willingly entered into the trust or escrow agreement and willingly deposited the money into the trust or escrow account; and

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b. none of the money in the account is paid over to the attorney unless and until SSA has authorized a fee for the attorney, and then only in an amount up to, but not exceeding, the authorized fee; and
c. any funds in the account in excess of the authorized fee will be refunded promptly to the claimant.

At the time the attorney petitions for a fee, the amount of money held in the trust or escrow account must be disclosed to SSA.

In title II and black lung cases, when the amount authorized by SSA as an attorney's fee is less than the total of (1) the money paid to the attorney from a trust or escrow account, and (2) the amount withheld from the claimant's past-due benefits for direct payment of the attorney's fee, SSA will reduce the amount of direct payment to the attorney by the amount that such total exceeds the authorized fee.
EXAMPLE: If the authorized fee is $ 1000, but the combined total of escrow payments ($ 600) and withheld benefits ($ 600) is $ 1200, SSA will pay $ 400 directly to the attorney out of withheld benefits and will release the remainder of withheld benefits ($ 200) to the claimant.

If the total of withheld past-due benefits and money paid from a trust or escrow account is

equal to or less than the amount of the authorized fee, there will be no reduction in the amount paid to the attorney from past-due benefits.

EFFECTIVE DATE: This policy is applicable to all claims or proceedings pending before SSA as of the publication of this policy statement. In any claim or proceeding where this policy was applied prior to the publication of this policy statement, such action will be deemed to have been taken properly and in accordance with interim procedures existing at that time.

DOCUMENTATION: A copy of the trust or escrow agreement or proof that any money from the trust or escrow account in excess of the authorized fee has been returned to the claimant must be provided to SSA upon request.

CROSS-REFERENCES: OHA Handbook, section 1-264(4); POMS sections GN 03920.001, GN 03920.070, GN 03970.005.

EXHIBIT "B"

HALLEX Section Dealing with Approval of Fee Petitions

I-1-230 PROCESSING FORM SSA-1560 (PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION) (REVISED 02/93)

Representatives should file Form SSA-1560 or a written statement providing the same information only when all services are completed.

NOTE: Fee authorizers generally will not accept supplemental fee petitions unless the representative has performed additional services after the initial fee authorization.

A. Upon receipt of a Form SSA-1560 or a written statement providing the same information [see 20 CFR 404.1725(a) and 416.1525(a)], the fee authorizing staff must take the following actions:

1. Date stamp the form or statement and associate it with the HO or the

Appeals file.

2. Determine whether the individual who filed the fee petition was duly appointed the claimant's representative on the Form SSA-1696 (Appointment of Representative) or other written document. (See I-1-110, Appointing a Representative.) If the individual who filed the fee petition was not duly appointed by the claimant, the fee authorizing staff will return the fee petition to the individual with a written explanation that only a claimant's duly appointed representative may charge and collect a fee.

3. Determine that the petition specifies the amount of the fee which the representative wants to charge. [20 CFR 404.1725(a)(3) and 416.1525(a)(3)]. The fee authorizing staff must return any petition which does not show a dollar amount.

NOTE: The fee authorizer must not attempt to convert a percentage amount to a dollar amount. Past-due title II benefits may be subject to offsets such as worker's compensation or overpayments. The fee authorizer should not speculate whether the representative is requesting a percentage of the past-due benefits before or after the offset is/was applied.

4. Confirm that the fee request shows that the representative sent a copy of the fee request to the claimant. If the representative did not do so, return the petition to the representative with a notice that the representative did not follow the procedures in 20 CFR 404.1725(a)(7).

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5. Diary the case for 30 days from the date of the fee petition for receipt of any comments from the claimant, unless the claimant's comments have been submitted with the fee petition, e.g., claimant has signed the Form SSA-1560 indicating agreement with the requested fee.

B. After the expiration of the 30-day diary period, the fee authorizer with jurisdiction over the fee petition must review the petition pursuant to the regulatory criteria (See I-1-240, Evaluating Fee Petitions) and make a fee determination, subject to the $5,000 limit. (See I-1-201 A., Authority to Approve Fees.)

I-1-240 EVALUATING FEE PETITIONS

The regulations do not specify maximum fees; rather, they prescribe criteria for evaluating fee petitions and determining reasonable fees for representatives [20 CFR 404.1725(b) and 416.1525(b)].

A. Criteria for Evaluating Fee Petitions

When evaluating fee petitions, the fee authorizer must consider the purpose of the Social Security program; namely, to provide a measure of economic security for program beneficiaries, together with—

- the extent and type of services performed;
- the complexity of the case;
- the level of skill and competence required in providing the services;
- the amount of time spent on the case;
- the results achieved by the representative;
- the level of review to which the claim was taken and the level of review at which the representation began; and,
- the amount of the fee requested.

B. Excluded Activities

In evaluating the amount of time a representative spent on the case, the fee authorizer must exclude any time claimed for:

1. Preparing the fee petition or any other activities related to charging or collecting a fee, such as status inquiries, and
2. Any services the representative performed before a state or federal court. EXCEPTION: Acquiescence Ruling 87-1(6), Webb v. Richardson, applies to fee authorizations in the Sixth Circuit (Michigan, Ohio, Tennessee and Kentucky).

C. Expenses

The representative's expenses are not considered part of the fee for services. The representative must look to the claimant for reimbursement of any expenses. 20 CFR 404.1725(b)(1)(vii) and 416.1525(b)(1)(vii).

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TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER II - FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Sec. 406. Representation of claimants before Commissioner

-STATUTE-

(a) Recognition of representatives; fees for representation before Commissioner

(1) The Commissioner of Social Security may prescribe rules and regulations governing recognition of agents or other persons, other than attorneys as hereinafter provided, representing claimants before the Commissioner of Social Security, and may require of such agents or other persons, before being recognized as representatives of claimants that they shall show that they are of good character and in good repute, possessed of the necessary qualifications to enable them to render such claimants valuable service, and otherwise competent to advise and assist such claimants in the presentation of their cases. An attorney in good standing who is admitted to practice before the highest court of the State, Territory, District, or insular possession of his residence or before the Supreme Court of the United States or the inferior Federal courts, shall be entitled to represent claimants before the Commissioner of Social Security. The Commissioner of Social Security may, after due notice and opportunity for hearing, suspend or prohibit from further practice before the Commissioner any such person, agent, or attorney who refuses to comply with the Commissioner's rules and regulations or who violates any provision of this section for which a penalty is prescribed. The Commissioner of Social Security may, by rule and regulation, prescribe the maximum fees which may be charged for services performed in connection with any claim before the Commissioner of Social Security under this subchapter, and any agreement in violation of such rules and regulations shall be void. Except as provided in paragraph (2)(A), whenever the Commissioner of Social Security, in any claim before the Commissioner for benefits under this subchapter, makes a determination favorable to the claimant, the Commissioner shall, if the claimant was represented by an attorney in connection with such claim, fix (in accordance with the regulations prescribed pursuant to the preceding sentence) a reasonable fee to compensate such attorney for the services performed by him in connection with such claim.

(2)(A) In the case of a claim of entitlement to past-due benefits under this subchapter, if -
(i) an agreement between the claimant and another person regarding any fee to be recovered by such person to compensate such person for services with respect to the claim

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is presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim,

(ii) the fee specified in the agreement does not exceed the lesser of -

(I) 25 percent of the total amount of such past-due benefits (as determined before any applicable reduction under section 1320a-6(a) of this title), or

(II) $4,000, and

(iii) the determination is favorable to the claimant,

then the Commissioner of Social Security shall approve that agreement at the time of the favorable determination, and (subject to paragraph (3)) the fee specified in the agreement shall be the maximum fee. The Commissioner of Social Security may from time to time increase the dollar amount under clause (ii)(II) to the extent that the rate of increase in such amount, as determined over the period since January 1, 1991, does not at any time exceed the rate of increase in primary insurance amounts under section 415(i) of this title since such date. The Commissioner of Social Security shall publish any such increased amount in the Federal Register.

(B) For purposes of this subsection, the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 423 of this title.

(C) In any case involving -

(i) an agreement described in subparagraph (A) with any person relating to both a claim of entitlement to past-due benefits under this subchapter and a claim of entitlement to past-due benefits under subchapter XVI of this chapter, and

(ii) a favorable determination made by the Commissioner of Social Security with respect to both such claims,

the Commissioner of Social Security may approve such agreement only if the total fee or fees specified in such agreement does not exceed, in the aggregate, the dollar amount in effect under subparagraph (A)(ii)(II).

(D) In the case of a claim with respect to which the Commissioner of Social Security has approved an agreement pursuant to subparagraph (A), the Commissioner of Social Security shall provide the claimant and the person representing the claimant a written notice of -

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(i) the dollar amount of the past-due benefits (as determined before any applicable reduction under section 1320a-6(a) of this title) and the dollar amount of the past-due benefits payable to the claimant,

(ii) the dollar amount of the maximum fee which may be charged or recovered as determined under this paragraph, and

(iii) a description of the procedures for review under paragraph (3).

(3)(A) The Commissioner of Social Security shall provide by regulation for review of the amount which would otherwise be the maximum fee as determined under paragraph (2) if, within 15 days after receipt of the notice provided pursuant to paragraph (2)(D) -

(i) the claimant, or the administrative law judge or other adjudicator who made the favorable determination, submits a written request to the Commissioner of Social Security to reduce the maximum fee, or

(ii) the person representing the claimant submits a written request to the Commissioner of Social Security to increase the maximum fee.

Any such review shall be conducted after providing the claimant, the person representing the claimant, and the adjudicator with reasonable notice of such request and an opportunity to submit written information in favor of or in opposition to such request. The adjudicator may request the Commissioner of Social Security to reduce the maximum fee only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered.

(B)(i) In the case of a request for review under subparagraph (A) by the claimant or by the person representing the claimant, such review shall be conducted by the administrative law judge who made the favorable determination or, if the Commissioner of Social Security determines that such administrative law judge is unavailable or if the determination was not made by an administrative law judge, such review shall be conducted by another person designated by the Commissioner of Social Security for such purpose.

(ii) In the case of a request by the adjudicator for review under subparagraph (A), the review shall be conducted by the Commissioner of Social Security or by an administrative law judge or other person (other than such adjudicator) who is designated by the Commissioner of Social Security.

(C) Upon completion of the review, the administrative law judge or other person conducting the review shall affirm or modify the amount which would otherwise be the maximum fee. Any such amount so affirmed or modified shall be considered the amount of the maximum fee which may be recovered under paragraph (2). The decision of the

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administrative law judge or other person conducting the review shall not be subject to further review.

(4)(A) Subject to subparagraph (B), if the claimant is determined to be entitled to past-due benefits under this subchapter and the person representing the claimant is an attorney, the Commissioner of Social Security shall, notwithstanding section 405(i) of this

title, certify for payment out of such past-due benefits (as determined before any applicable reduction under section 1320a-6(a) of this title) to such attorney an amount equal to so much of the maximum fee as does not exceed 25 percent of such past-due benefits (as determined before any applicable reduction under section 1320a-6(a) of this title).

(B) The Commissioner of Social Security shall not in any case certify any amount for payment to the attorney pursuant to this paragraph before the expiration of the 15-day period referred to in paragraph (3)(A) or, in the case of any review conducted under paragraph (3), before the completion of such review.

(5) Any person who shall, with intent to defraud, in any manner willfully and knowingly deceive, mislead, or threaten any claimant or prospective claimant or beneficiary under this subchapter by word, circular, letter or advertisement, or who shall knowingly charge or collect directly or indirectly any fee in excess of the maximum fee, or make any agreement directly or indirectly to charge or collect any fee in excess of the maximum fee, prescribed by the Commissioner of Social Security shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall for each offense be punished by a fine not exceeding $500 or by imprisonment not exceeding one year, or both. The Commissioner of Social Security shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Commissioner of Social Security, of the identity of any person representing such claimant in accordance with this subsection.

(b) Fees for representation before court

(1)(A) Whenever a court renders a judgment favorable to a claimant under this subchapter who was represented before the court by an attorney, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25 percent of the total of the past-due benefits to which the claimant is entitled by reason of such judgment, and the Commissioner of Social Security may, notwithstanding the provisions of section 405(i) of this title, certify the amount of such fee for payment to such attorney out of, and not in addition to, the amount of such past-due benefits. In case of any such judgment, no other fee may be payable or certified for payment for such representation except as provided in this paragraph.

(B) For purposes of this paragraph -

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(i) the term "past-due benefits" excludes any benefits with respect to which payment has been continued pursuant to subsection (g) or (h) of section 423 of this title, and

(ii) amounts of past-due benefits shall be determined before any applicable reduction

under section 1320a-6(a) of this title.

(2) Any attorney who charges, demands, receives, or collects for services rendered in connection with proceedings before a court to which paragraph (1) of this subsection is applicable any amount in excess of that allowed by the court thereunder shall be guilty of a misdemeanor and upon conviction thereof shall be subject to a fine of not more than $500, or imprisonment for not more than one year, or both.

(c) Notification of options for obtaining attorneys The Commissioner of Social Security shall notify each claimant in writing, together with the notice to such claimant of an adverse determination, of the options for obtaining attorneys to represent individuals in presenting their cases before the Commissioner of Social Security. Such notification shall also advise the claimant of the availability to qualifying claimants of legal services organizations which provide legal services free of charge.

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(Aug. 14, 1935, ch. 531, title II, Sec. 206, 49 Stat. 624; Aug. 10, 1939, ch. 666, title II, Sec. 201, 53 Stat. 1362, 1372; Aug. 28, 1950, ch. 809, title I, Sec. 109(b)(1), 64 Stat. 523; Aug. 28, 1958, Pub. L. 85-840, title III, Sec. 309, 72 Stat. 1034; July 30, 1965, Pub. L. 89-97, title III, Sec. 332, 79 Stat. 403; Jan. 2, 1968, Pub. L. 90-248, title I, Sec. 173, 81 Stat. 877; Dec. 19, 1989, Pub. L. 101-239, title X, Sec. 10307(a)(1), (b)(1), 103 Stat. 2484, 2485; July 18, 1984, Pub. L. 98-369, title VI, Sec. 2663(l)(1), 98 Stat. 1171; Nov. 5, 1990, Pub. L. 101-508, title V, Sec. 5106(a)(1), 104 Stat. 1388-266; Aug. 15, 1994, Pub. L. 103-296, title I, Sec. 107(a)(4), title III, Sec. 321(f)(3)(B)(i), (4), 108 Stat. 1478, 1541, 1542.)

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AMENDMENTS

1994 - Subsec. (a)(1), (2)(A). Pub. L. 103-296, Sec. 107(a)(4), substituted "Commissioner of Social Security" for "Secretary" wherever appearing, "before the Commissioner" for "before him" in two places, "Commissioner's" for "Secretary's" in two places, and "the Commissioner shall, if the" for "he shall, if the" in par. (1).

Subsec. (a)(2)(C). Pub. L. 103-296, Sec. 321(f)(4)(A)(ii), added subpar. (C). Former subpar. (C) redesignated (D). Pub. L. 103-296, Sec. 107(a)(4), in subpar. (C) as added by Pub.L. 103-296, Sec. 321(f)(4)(A)(ii), substituted "Commissioner of Social Security" for "Secretary" in two places.

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Subsec. (a)(2)(D). Pub. L. 103-296, Sec. 321(f)(4)(A)(i), redesignated subpar. (C) as (D). Pub. L. 103-296, Sec. 107(a)(4), in subpar. (D) as predesignated byPub. L. 103-296,

Sec. 321(f)(4)(A)(i), substituted ''Commissioner of Social Security'' for ''Secretary'' in two places in introductory provisions.

Subsec. (a)(3)(A). Pub. L. 103-296, Sec. 321(f)(4)(B), substituted ''paragraph (2)(D)'' for ''paragraph (2)(C)'' in introductory provisions. Pub. L. 103-296, Sec. 107(a)(4), substituted ''Commissioner of Social Security'' for ''Secretary'' wherever appearing.

Subsec. (a)(3)(B), (4), (5). Pub. L. 103-296, Sec. 107(a)(4), substituted ''Commissioner of Social Security'' for ''Secretary'' wherever appearing.

Subsec. (b)(1). Pub. L. 103-296, Sec. 321(f)(3)(B)(i), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (b)(1)(A). Pub. L. 103-296, Sec. 107(a)(4), in subpar.(A) as designated by Pub. L. 103-296, Sec. 321(f)(3)(B)(i), substituted ''Commissioner of Social Security'' for ''Secretary''.

Subsec. (c). Pub. L. 103-296, Sec. 107(a)(4), substituted ''Commissioner of Social Security'' for ''Secretary'' in two places.

1990 - Subsec. (a). Pub. L. 101-508 designated existing provisions as par. (1), substituted ''Except as provided in paragraph (2)(A), whenever'' for ''Whenever'' in fifth sentence, substituted pars. (2) to (4) for ''If as a result of such determination, such claimant is entitled to past-due benefits under this subchapter, the Secretary shall, notwithstanding section 405(i) of this title, certify for payment (out of such past-due benefits) to such attorney an amount equal to whichever of the following is the smaller: (A) 25 per centum of the total amount of such past-due benefits, (B) the amount of the attorney's fee so fixed, or (C) the amount agreed upon between the claimant and such attorney as the fee for such attorney's services.'', and inserted ''(5)'' before ''Any person who''.

1989 - Subsec. (a). Pub. L. 101-239, Sec. 10307(a)(1), inserted at end ''The Secretary shall maintain in the electronic information retrieval system used by the Social Security Administration a current record, with respect to any claimant before the Secretary, of the identity of any person representing such claimant in accordance with this subsection.''

Subsec. (c). Pub. L. 101-239, Sec. 10307(b)(1), added subset.(c). 1984 - Pub. L. 98-369 substituted ''Secretary'' and ''Secretary's'' for ''Administrator'' and ''Administrator's'', respectively, wherever appearing. 1968 - Subsec. (a). Pub. L. 90-248 provided for fixing of attorneys fees for claimants and for certification of amount for payment out of past-due benefits. 1965 - Pub. L. 89-97 designated existing provisions as subset. (a) and added subsec. (b). 1958 - Pub. L. 85-840 struck out provisions which required attorneys to file a

certificate of their right to practice.1950 - Act Aug. 28, 1950, substituted "Administrator" for "Board" and "Administrator's" for "Board's". 1939 - Act Aug. 10, 1939, substituted the provisions of this section for former provisions relating to overpayments during life, now covered by section 404 of this title.

EFFECTIVE DATE OF 1994 AMENDMENT

Amendment by section 107(a)(4) of Pub. L. 103-296 effective Mar. 31, 1995, see section 110(a) of Pub. L. 103-296, set out as a note under section 401 of this title.

Amendment by section 321(f)(3)(B)(i), (4) of Pub. L. 103-296 effective as if included in the provisions of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508, to which such amendment relates, except that amendment by section 321(f)(3)(B)(i) applicable with respect to favorable judgments made after 180 days after Aug. 15, 1994, see section 321(f)(5) of Pub. L. 103-296, set out as a note under section 405 of this title.

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101-508 applicable with respect to determinations made on or after July 1, 1991, and to reimbursement for travel expenses incurred on or after Apr. 1, 1991, see section 5106(d) of Pub. L. 101-508, set out as a note under section 401 of this title.

EFFECTIVE DATE OF 1989 AMENDMENT

Section 10307(a)(3) of Pub. L. 101-239 provided that: "The amendments made by this subsection (amending this section and section 1383 of this title) shall take effect June 1, 1991." Section 10307(b)(3) of Pub. L. 101-239 provided that: "The amendments made by this subsection (amending this section and section 1383 of this title) shall apply with respect to adverse determinations made on or after January 1, 1991."

EFFECTIVE DATE OF 1939 AMENDMENT

Section 201 of act Aug. 10, 1939, provided that the amendment made by that section is effective Jan. 1, 1940.

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SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 423, 1320a-6, 1383, 1395ff, 1395ii of this title; title 30 section 923.

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