RUNNING THE GAUNTLET: *WOLCOTT V. SEBELIUS* REVEALS LOOPHOLES IN THE MEDICARE PART B APPEALS PROCESS THAT THE FIFTH CIRCUIT CANNOT (OR WILL NOT) CLOSE

Comment

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Power has only one duty—to secure the social welfare of the People.
Benjamin Disraeli

Justice delayed is justice denied.
William E. Gladstone

The most common way people give up their power is by thinking they don't have any.
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I. INTRODUCTION

Since its creation in 1965, Medicare has never wanted for criticism.[1] Medicare is a huge cost to taxpayers that accounts for nearly 13% of all federal spending.[2] With costs soaring toward figures reaching unsustainable levels, it is no wonder that Congress has persistently sought to cut Medicare costs by promoting efficiency and eliminating fraud.[3] Although all administrative levels could improve in efficiency, one particular area is severely lacking—the process of reimbursing physicians and hospital providers for medical treatments and devices.[4] The reimbursement process has long been criticized as a burdensome administrative process that results in economic waste.[5] With the passage of the Affordable Care Act, Medicare stands to be an even greater source of health care provisions and fraud prevention, which will most likely

1. *See, e.g.*, Avedis Donabedian, *Issues in National Health Insurance*, 66 AM. J. PUB. HEALTH 345, 346 (1976) (criticizing insurance plans in the 1970s and the unfair distribution of Medicare, which seemed to favor physicians' families rather than the poor); Kenneth R. Wing, *Medicare and President Reagan's Second Term*, 75 AM. J. PUB. HEALTH 782, 783 (1985) (discussing the rising inflation of Medicare during Reagan's second term and the strategy of democrats and republicans to solve the problem of Medicare's rising inflation costs to prevent its collapse).

2. Tom Costello, *How Will 'Fiscal Cliff' Affect Medicare?*, NBC NEWS (Nov. 28, 2012), http://video.msnbc.msn.com/nightly-news/50001923/#50001923.

3. *See* Sally C. Pipes, *Medicare Cliff Looms: Status Quo Isn't Sustainable*, HILL'S CONGRESS BLOG (Jan. 31, 2013, 11:00 AM), http://thehill.com/blogs/congress-blog/healthcare/280143-medicare-cliff-looms-status-quo-isnt-sustainable; 2012 REPUBLICAN PLATFORM: WE BELIEVE IN AMERICA 21, *available at* http://www.gop.com/wp-content/uploads/2012/08/2012GOPPlatform.pdf; 2012 DEMOCRATIC NATIONAL PLATFORM: MOVING AMERICA FORWARD 4, *available at* http://assets.dstatic.org/dnc-platform/2012-National-Platform.pdf.

4. *See* John D. Shatto & M. Kent Clemens, *Projected Medicare Expenditures Under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1-2 (May 18, 2012), *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2012TRAlternativeScenario.pdf.

5. *See* Timothy P. Blanchard, *Medicare Medical Necessity Determinations Revisited: Abuse of Discretion and Abuse of Process in the War Against Medicare Fraud and Abuse*, 43 ST. LOUIS U. L.J. 91, 92 (1999) (noting the constant legislative and policy debate surrounding health care costs and why certain Medicare administrative processes have become "abuses of process and abuses of discretion").

lead to an even greater number of reimbursement denials and appeals.[6] Many people only think of Medicare waste as an important political issue, but it also impacts lawyers in all jurisdictions as Medicare more and more aggressively targets fraudulent activity and as the diverse fields of criminal, health, business, and administrative law collide.[7]

These areas of law intersect when Medicare investigates medical service providers for fraudulent reimbursement claims; once the providers have been cleared, they often find themselves victims of endless denials of reimbursement for medical services.[8] Fraud investigation is an important tool in Medicare's waste-eliminating arsenal because fraud also contributes to the high cost of Medicare.[9] When an innocent medical service provider undergoes a fraud investigation, oftentimes fraud prevention and fraud enforcement add more money to Medicare's ever-increasing costs.[10] Consider, for example, a medical service provider who performs the same procedure on a routine basis and who is flagged for fraud investigation because he performs a high volume of those procedures.[11] Medicare questions if such a large volume of procedures are truly necessary.[12] Recently, a case of first impression in the Fifth Circuit raised questions of efficiency and fairness for medical service providers appealing thousands of claims based on similar medical procedures.[13]

In 2007, Medicare conducted a fraud investigation of Randall Wolcott, M.D., P.A., a Lubbock-area wound specialist.[14] Medicare suspended all of

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6. *See* U.S. Dep't of Health & Human Servs. & U.S. Dep't of Justice, *Fraud Prevention Efforts Recover $4 Billion*, STOP MEDICARE FRAUD, (Sept. 24, 2012), http://www.stopmedicarefraud.gov/videos/2011/01/prevention-efforts-recover.html ("A joint effort by HHS and the Department of Justice recovered a record $4 billion from fraudsters in FY2010. And thanks to the Affordable Care Act, new tools will help prevent and fight health care fraud, saving taxpayer dollars and strengthening Medicare for patients.").

7. *See id.*; *see also Reporting Fraud*, MEDICARE.GOV., http://www.medicare.gov/forms-help-and-resources/report-fraud-and-abuse/report-fraud/reporting-fraud.html (last visited Mar. 20, 2013) (informing individuals how to report Medicare fraud).

8. *See* discussion *infra* Part II.B.2.

9. *See* Costello, *supra* note 2; *see also* News Release, U.S. Dep't of Justice, Medicare Fraud Strike Force Charges 91 Individuals for Approximately $430 Million in False Billing (Oct. 4, 2012), http://www.justice.gov/opa/pr/2012/October/12-ag-1205.html.

10. *See* Anna M. Grizzle, *Compliance Advice for Health Care Lawyers and Clients*, *in* HEALTH CARE LAW ENFORCEMENT AND COMPLIANCE: LEADING LAWYERS ON UNDERSTANDING RECENT TRENDS IN HEALTH CARE ENFORCEMENT, UPDATING COMPLIANCE PROGRAMS, AND DEVELOPING CLIENT STRATEGIES 7 (2012 ed.), *available at* 2012 WL 4459387, at *1, *3; FED. BUREAU OF INVESTIGATION, FINANCIAL CRIMES REPORT TO THE PUBLIC: FISCAL YEARS 2010-2011, *available at* http://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011 (last visited June 6, 2013).

11. *See* Grizzle, *supra* note 10, at *3; *see also* discussion *infra* Part II.A.3.

12. *See* Daniel A. Cody, *An Examination of the Impact of the Patient Protection and Affordable Care Act and Other Current Developments*, *in* HEALTH CARE LAW ENFORCEMENT AND COMPLIANCE, *supra* note 10, at 37, *available at* 2012 WL 4459388, at *1.

13. *See* Wolcott v. Sebelius (*Wolcott I*), 635 F.3d 757, 762 (5th Cir. 2011). This case will hereinafter be referred to as *Wolcott I* so as to distinguish it from *Wolcott v. Sebelius* (*Wolcott II*), 497 F. App'x 400 (5th Cir. 2012) (per curiam), which was the resolution of the first case and which will similarly be referred to as *Wolcott II*.

14. Interview with Randall D. Wolcott, M.D., P.A., Dir., Sw. Reg'l Wound Care Ctr., in Lubbock, Tex. (Sept. 30, 2012). I developed a personal interest in this topic when I worked for Dr. Wolcott during this time.

Wolcott's payments for a period of one year until the investigation was closed, and Medicare determined Wolcott had not engaged in any fraudulent activity.[15] Medicare, however, persisted in denying reimbursement for the procedures it had actively investigated.[16] In 2010, Wolcott brought a mandamus action against Kathleen Sebelius in her official capacity as Secretary of the United States Department of Health and Human Services to order payment of $750,000 of reimbursement denials.[17] Wolcott claimed he was facing a seemingly endless and inescapable gauntlet of denials because Medicare did not honor favorable decisions by Administrative Law Judges (ALJs).[18] Wolcott is not the only medical service provider facing these issues.[19] Doctors and hospitals, whose main source of income derives from Medicare, often find themselves in a vicious circle of denials that are reversed by an ALJ, which Medicare then re-denies for a different reason.[20] The lines between fraud and inefficiency blur when Medicare, after finding no fraud, still treats medical service providers as if their activities were fraudulent.[21] In order to prevent fraud and evaluate claims for reimbursement, Medicare reviews procedures on a case-by-case basis.[22] Medicare employs thousands of agency officials and agency contractors to evaluate these claims at each level of the appeals process.[23] Not all decision makers involved in this process, however, have the necessary medical training and skills to properly evaluate reasonable medical necessity for specialized areas of medicine, and thousands of claims are sent through multiple levels of appeals, which wastes both the medical service provider's and Medicare's time and resources.[24] Most importantly, these conflicts ultimately pass the burden onto patients who may not receive adequate medical care because Medicare effectively binds the hands of the physician or medical service provider.[25]

Part II.A of this Comment provides a brief background of Medicare and its appeals process in order to illustrate the unjustifiable, inefficient, and unfair loophole that exists in the current Medicare administrative structure.[26] Part II.B describes the facts of *DeWall Enterprises, Inc. v. Thompson* and *Wolcott v.*

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15. *See id.*

16. *See id.*

17. *See Wolcott I*, 635 F.3d at 764.

18. *See id.*

19. *See, e.g.*, DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 1001 (D. Neb. 2002) (holding that Medicare had abused the medical service provider by denying claims for the same reason so many times that the medical service provider was being run out of business).

20. *See Wolcott I*, 635 F.3d at 762; *DeWall*, 206 F. Supp. 2d at 996.

21. *See DeWall*, 206 F. Supp. 2d at 996.

22. *See* 42 U.S.C. § 1395y (2011).

23. *See Part A/Part B Medicare Administrative Contractor*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/Medicare/Medicare-Contracting/MedicareContractingReform/PartAandPartBMedicareAdministrativeContractor.html (last visited Jan. 31, 2013).

24. Interview with Bridget Eubanks, Medicare Appeals Specialist, Sw. Reg'l Wound Care Ctr., in Lubbock, Tex. (Oct. 19, 2012).

25. *See Wolcott I*, 635 F.3d at 761; *DeWall*, 206 F. Supp. 2d at 1001-02.

26. *See Wolcott I*, 635 F.3d at 774; *DeWall*, 206 F. Supp. 2d at 1001.

Sebelius, which reveal that even if a medical service provider receives a *favorable* decision from an ALJ or the Medicare Appeals Council, Medicare can continue to re-deny the exact same claims, forcing the provider to restart the appeals process all over again.[27] In *DeWall* and *Wolcott I*, both medical service providers appealed thousands of claims.[28] *DeWall* illustrates a glaring lack of recourse for medical service providers in these situations.[29] In *Wolcott II*, the Fifth Circuit became the tenth federal circuit court to address this issue and the first federal circuit court to encounter this issue after the *DeWall* ruling.[30] The Fifth Circuit, however, did not provide any analysis or commentary on *DeWall*, thus leaving the question open as to how other courts would apply this case.[31] Mandamus relief, however, is only one course of action that could close this loophole in the Medicare appeals process.[32]

Part III of this Comment addresses why an Article III court such as the Fifth Circuit could have granted Wolcott mandamus relief and bound Medicare to ALJ rulings between the specific parties involved.[33] Part IV explains the delicate issue of judicial deference to agency action and why, perhaps, the Fifth Circuit, like previous circuits, avoided granting mandamus.[34] Part V of this Comment advises courts to be confident in granting mandamus in appropriate administrative settings because mandamus is currently the only remedy

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27. *See Wolcott I*, 635 F.3d at 774; *DeWall*, 206 F. Supp. 2d at 1001. An appeal before an ALJ is the third step in the Medicare appeals process, and the Medicare appeals council is the fourth step. *See* discussion *infra* Part II.A.2.

28. *See Wolcott I*, 635 F.3d at 759; *DeWall*, 206 F. Supp. 2d at 1001.

29. *See Wolcott II*, 497 F. App'x 400, 402-03 (5th Cir. 2012) (per curiam).

30. *See* Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 813 (D.C. Cir. 2001); Cordoba v. Massanari, 256 F.3d 1044, 1047 (10th Cir. 2001); Buchanan v. Apfel, 249 F.3d 485, 491-92 (6th Cir. 2001); U.S. *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 508-09 (4th Cir. 1999); Briggs v. Sullivan, 886 F.2d 1132 (9th Cir. 1989); Burnett v. Bowen, 830 F.2d 731 (7th Cir. 1987); City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984); Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983); Colonial Penn Ins. Co. v. Heckler, 721 F.2d 431 (3d Cir. 1983); *see also* discussion *infra* Part II.B.2.

31. *See Wolcott II*, 497 F. App'x at 406-08.

32. *See* discussion *infra* Parts VI-VII.

33. *See* discussion *infra* Part II.A. Article III of the U.S. Constitution authorizes the creation of courts that include our traditional system of district courts, appellate courts, and the Supreme Court, which is why these courts are often referred to as Article III courts. *See* U.S. CONST. art. III, § 1 ("The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish."). I use the term "Article III courts" to distinguish from "Article I courts" such as tax courts, bankruptcy courts, and the Court of Appeals for Veterans Claims, which are created by Congress. *See generally* Richard Revesz, *Specialized Courts and the Administrative Lawmaking System*, 138 U. PA. L. REV. 1111 (1990) (discussing the advantages and disadvantages of judicial review by specialized courts created by Congress under the Article I power).

34. *See, e.g.*, Amy Rogers, *Administrative Law: Statute Restricting Judicial Review of Medicare Reimbursement Decisions Applies to Actions Brought by the United States*—United States v. University of Massachusetts Memorial Medical Center*, 296 F. Supp. 2d 20 (D. Mass. 2003)*, 30 AM. J.L. & MED. 103, 104 (2004) (emphasizing the tendency of courts to "give great deference to the Secretary's interpretation of its reimbursement regulations because of the specific medical expertise needed to make such determinations"). Additionally, Medicare agency employees are supposed to be experts in their field, whereas most federal judges do not specialize in health law. 2 CHARLES H. KOCH, JR., ADMINISTRATIVE LAW AND PRACTICE § 5.72, at 304 (3d ed. 2010).

available to medical service providers.[35] Part VI urges Congress to afford other remedies for service providers by drafting a statute that creates a cause of action for a medical service provider to recover attorneys' fees and treble damages if the medical service provider's routine standard of care is found to be medically necessary and reasonable and if Medicare refused to reimburse the provider.[36] Finally, Part VII proposes one last simple solution that could be implemented rather quickly, would reduce the costs of Medicare appeals, and would allow Medicare to focus its attention on medical service providers who are actually engaging in fraudulent activity—the retention of independent medical-specialist experts to advise the agency at steps three and four of the Medicare appeals process.[37]

II. BACKGROUND

A. Medicare

The Medicare program provides health insurance for persons aged sixty-five or older and disabled persons of any age.[38] The program is divided into two parts: Medicare Part A and Medicare Part B.[39] Medicare Part A provides coverage for costs associated with hospital care.[40] Medicare Part B is a voluntary health insurance program and provides supplemental insurance coverage for certain coverage excluded from Part A.[41] Part B coverage includes outpatient physicians' services rendered in a clinical setting and medical devices—the coverage at issue in *Wolcott* and *DeWall*, respectively.[42] Accordingly, this Comment only addresses the administrative process for Medicare Part B.

1. The Medicare Part B Payment Process

When a supplier of medical services provides a service to a Medicare patient, either the patient or the medical service provider, having been assigned the right to payment by the patient, files a claim with Medicare.[43] The patient, by assigning his or her right to payment, allows the medical service provider to step into the shoes of the patient; therefore, the beneficiary has the same rights

35. *See* discussion *infra* Part V.
36. *See* discussion *infra* Part VI.
37. *See* discussion *infra* Part VII.
38. *See* 42 U.S.C. §§ 1395-1395kkk (2011).
39. *See* 42 U.S.C. §§ 1395c-1395w (2011).
40. *See* §§ 1395c-1395i.
41. *See* §§ 1395j-1395w.
42. *See id.*; *Wolcott I*, 635 F.3d 757, 760 (5th Cir. 2011); DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 994 (D. Neb. 2002).
43. *See* § 1395u(b)(3).

to payment and rights to appeal as the patient.[44] The claim is sent to a private company that has contracted with Medicare and that will perform the following actions:

- "Determine if the items and services on the claim are covered or reimbursable by Medicare;
- Calculate any amount that is payable by Medicare;

. . .

- Notify [the party seeking reimbursement] of its decision to pay or deny coverage or payment for specific items or services."[45]

The majority of Medicare's funding goes to reimbursement for medical procedures, services, or devices.[46] Medicare protects its resources by making sure doctors are only reimbursed for providing treatments, services, or devices that are medically reasonable and necessary.[47] The contractor evaluates whether the medical device or service was "reasonable and necessary."[48] This evaluation is based on guidelines set forth by the agency.[49] Medicare also uses the Recovery Audit Prepayment Review, which targets "certain types of claims that historically result in high rates of improper payments."[50] Either through the automated process or the review of an auditor, the claim will be approved or

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44. *See* 42 C.F.R. § 405.906 (2012). It is important to note that although most of the cases referenced in this Comment deal with medical service providers, one should always keep in mind that the provider is a beneficiary for the *patient* and that a patient's adequate medical treatment is the central reason why the administrative process should be efficient and fair. *See id.*

45. Office of Medicare Hearings & Appeals (OMHA), *Level 1 Appeal: Original Medicare* (*Parts A & B)*, U.S. DEP'T HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/process/level1/l1_ab.html (last visited Apr. 17, 2013) [hereinafter OMHA, *Level I Appeal*].

46. *See* Shatto & Clemens, *supra* note 4, at 1-2.

47. *See* 42 U.S.C. § 1395y (2011).

48. *Id.* "The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 371(h) of title 21." § 1395y(l)(1).

49. *See* § 1395y(l)(1); 21 U.S.C. § 371(g) (2011).

50. *Recovery Audit Prepayment Review*, CTRS. MEDICARE & MEDICAID SERVS., http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/RAC-Prepay-Review.html (last visited Jan. 11, 2013). The Centers state,

> These reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration will also help lower the error rate by preventing improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur. This demonstration began on September 1, 2012.

Id. This automated process was called "Automated Prepayment Review" prior to September 1, 2012. *See* CMS Medicare Manual System, Pub. 100-8 Program Integrity, Transmittal 39 (Mar. 14, 2003), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R39PI.pdf.

denied.[51] If Medicare denies the claim, the medical service provider can appeal through a five-step process.[52]

2. The Medicare Part B Appeals Process

When Medicare denies compensation for a procedure or series of procedures, a doctor may contest the denial.[53] Once the provider receives an initial determination, if he is "dissatisfied" with the initial determination, the first step of appeal is to request a redetermination by the carrier.[54] "A redetermination is performed by the same contractor that processed [the original] Medicare claim. However, the individual that performs the appeal is not the same individual that processed [the original] claim. The appeal is a new and independent review of [the] claim."[55] If the individual seeking appeal is dissatisfied with the result of the redetermination, he may then seek "reconsideration" by a "Qualified Independent Contractor."[56] Third, either aggrieved party may request a hearing before an ALJ.[57] The ALJ is appointed by the Department of Health and Human Services Office of Medicare Hearings and Appeals.[58] Fourth, if a party finds the ALJ's decision unfavorable, he may request review by the Medicare Appeals Council.[59] Fifth, and finally, either party dissatisfied with the Medicare Appeals Council's decision may seek judicial review in an Article III court.[60] The Office of Medicare Hearings and Appeals provides information on its website that describes this process, stating that "[i]f you disagree with your Medicare Appeals Council (MAC) Level 4 decision and the amount in controversy is at least $1,350 (2012), you may file a civil action in your local Federal District Court. . . . This is the last level of

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51. *See* 42 C.F.R. § 405.920 (2012).

52. *See* 42 C.F.R. §§ 405.940-.1140 (2012).

53. *See id.*

54. 42 C.F.R. § 405.940.

55. OMHA, *Level I Appeal*, *supra* note 45.

56. *See* 42 C.F.R. § 405.960. "A Qualified Independent Contractor (QIC), retained by CMS, will conduct the Level 2 appeal, called a reconsideration in Medicare Parts A & B. QICs have their own physicians and other health professionals to independently review and assess the medical necessity of the items and services pertaining to your case." Office of Medicare Hearings & Appeals (OMHA), *Level 2 Appeals: Original Medicare* (*Parts A & B)*, U.S. DEP'T HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/process/level2/l2_ab.html (last visited Apr. 17, 2013).

57. *See* 42 C.F.R. § 405.1000. "A hearing before an OMHA ALJ gives you the opportunity to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision in accordance with the applicable law." Office of Medicare Hearings & Appeals (OMHA), *Level 3 Appeals*, U.S. DEP'T HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/process/level3/index.html (last visited Apr. 17, 2013).

58. *See Qualification Standard for Administrative Law Judge Positions*, U.S. OFF. PERS. MGMT., http://www.opm.gov/qualifications/alj/alj.asp (last visited Apr. 17, 2013).

59. *See* 42 C.F.R. § 405.1100 (2012). The Medicare Appeals Council is "[p]art of the Departmental Appeals Board of the Department of Health and Human Services (HHS), and is . . . [i]ndependent of OMHA and its ALJs." Office of Medicare Hearings & Appeals (OMHA), *Level 4 Appeals*, U.S. DEP'T HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/process/level4/index.html (last visited Apr. 17, 2013).

60. *See* 42 C.F.R. § 405.1136 (2012).

appeals[—]Level 5."[61] Notice that the Office of Medicare Hearings and Appeals explains that one who *disagrees* with the MAC decision may seek redress in a federal court.[62] The department is silent as to what process is afforded to a provider who is satisfied with the previous decisions but who has yet to be paid for his claims.[63] In step five of the Medicare Appeals process, a federal district court reviews the claims of the provider and evaluates the decisions of the previous adjudications.[64]

This five-step reimbursement and appeals process is seemingly simple.[65] On any given day, a Medicare patient will visit a doctor, the doctor will perform a procedure, and the patient or medical service provider will apply for reimbursement of that procedure.[66] If that procedure is denied, the patient can choose to follow the five-step appeals process that Medicare has created.[67] A single denial may not seem that daunting, and a five-step appeals process seems to afford the patient or medical service provider ample opportunity to contest denial of reimbursement.[68] The Office of Medicare Hearings and Appeals, however, does not address the loophole created when medical service providers must appeal thousands of similar claims.[69] In *DeWall v. Thompson*, the court looked past a single five-step process to multiple appeals that a provider must go through to settle a similar issue each time.[70] To cure this procedural defect, the *DeWall* court granted mandamus relief, ordering the Secretary of the Department of Health and Human Services to stop denying subsequent claims for identical issues with the same provider.[71] *Wolcott v. Sebelius* also sought to cure this defect through mandamus relief.[72] A circuit court has never directly ruled on this issue, so the Fifth Circuit would have been the first to follow the *DeWall* reasoning to grant mandamus to preclude an agency from relitigating the same issue previously determined in an earlier adjudication.[73] In fact, until recently, the Fifth Circuit did not even recognize that it had the jurisdiction to

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61. Office of Medicare Hearings & Appeals (OMHA), *Level 5 Appeals*, U.S. DEP'T HEALTH & HUMAN SERVS., http://www.hhs.gov/omha/process/level5/index.html (last visited Apr. 17, 2013) [hereinafter OMHA, *Level 5 Appeals*].

62. *Id.*

63. *See id.*; *see also* discussion *infra* Part II.B.1-2.

64. *See* 42 C.F.R. § 405.1136.

65. *See* Andrew B. Wachler & Abby Pendleton, *The New Medicare Appeals Process*, 17 HEALTH L. 8, 9 (2005).

66. *See, e.g.*, Robert A. Berenson, MD & Eugene C. Rich, MD, *US Approaches to Physician Payment: The Deconstruction of Primary Care*, 25 J. GEN. INTERNAL MED. 613, 613 (2010) (discussing the process and impact of the system of medical payment in the United States).

67. *See* 42 C.F.R. §§ 405.940-.1140 (2012).

68. *See* Wachler & Pendleton, *supra* note 65, at 17.

69. *See Wolcott I*, 635 F.3d 757, 761-62 (5th Cir. 2011); DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 993 (D. Neb. 2002).

70. *See DeWall*, 206 F. Supp. 2d at 993.

71. *See id.* at 994.

72. *See Wolcott I*, 635 F.3d at 764.

73. *See* Brief of Plaintiff-Appellant at 6, *Wolcott I*, 635 F.3d 757 (No. 10-10290) [hereinafter *Wolcott I* Brief].

grant mandamus relief.[74] In considering grants of mandamus to medical service providers, courts should also consider the policy reasons behind Medicare's denials of some reimbursements in pursuit of fraud enforcement.

3. Medicare Fraud and Enforcement

Medicare fraud investigation begins with the initial reimbursement step of the Medicare payment process.[75] A medical service provider engages in fraudulent activity if it knowingly submits a false reimbursement claim.[76] The Fraud Enforcement and Recovery Act of 2009 (FERA) has somewhat updated the False Claims Act by speeding up civil investigation demand procedures (CIDs).[77] FERA is a step in the right direction toward streamlining the efficiency of fraud investigation. One method Medicare uses to detect fraud is through the use of "sophisticated data mining techniques to uncover potential fraudulent activity."[78] The data is used to detect "specific trends suggesting fraud."[79] According to one researcher, "these data mining efforts focus on medical procedures or devices having high levels of reimbursement or claims submissions indicating excessive utilization of certain procedures or codes."[80] This tool, however, is becoming a double-edged sword that not only detects fraud but also targets medical service providers who are not engaged in fraudulent activity but who perform a high volume of services.[81] Two cases in particular illustrate the damage that can be done to innocent medical service providers caught in the web of these data mining tools: *DeWall* and *Wolcott I*.[82] Although the cases deal with the non-reimbursement to medical service providers, the end result of this sort of administrative loophole ultimately affects the care of patients.

B. Medicare and Non-Fraudulent Medical Service Providers: Two Precedential Cases

1. DeWall Enterprises, Inc. v. Thompson

In *DeWall Enterprises, Inc. v. Thompson*, the U.S. District Court for the District of Nebraska became the first court to grant mandamus relief in the form of collaterally estopping an agency from relitigating identical issues with the

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74. *See Wolcott I*, 635 F.3d at 765-66; discussion *infra* Part III.A.
75. Barton Carter et al., *Health Care Fraud*, 34 AM. CRIM. L. REV. 713, 717 (1997).
76. False Claims Act (FCA), 18 U.S.C. § 287 (2006).
77. *See* Grizzle, *supra* note 10, at *3.
78. *See* Cody, *supra* note 12, at *6.
79. *See id.*
80. *See id.*
81. *See Wolcott I*, 635 F.3d 757, 770 (5th Cir. 2011); DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 998 (D. Neb. 2002).
82. *See Wolcott I*, 635 F.3d at 770; *DeWall*, 206 F. Supp. 2d at 998.

same medical service provider over the coding information of a medical device.[83] It was also the first court to recognize the administrative loophole that only allowed a party to appeal an unfavorable decision by an agency decision maker.[84] The *DeWall* court granted preliminary injunctive relief in the form of mandamus to a medical equipment supplier who continued to appeal claims that Medicare continually denied for the exact same issue each time.[85] "In 1991 DeWall became a 'participating supplier of durable medical equipment' under Part B of the Medicare Program . . . ."[86] Also in 1991, a regional carrier for Medicare "denied a claim for the DeWall posture protector submitted under Code L0430."[87] At the reconsideration hearing (the second level of the Medicare Part B process), the hearing officer determined L0430 to be the proper code.[88] In 1995, Medicare claimed it had overpaid DeWall for reimbursements in the amount of $445,000 because DeWall had used the wrong billing code for a certain medical device.[89] In 1997, ALJ Robert H. Burgess found that DeWall had used the correct billing code (i.e., L0430).[90] In 1996, Medicare, again claiming DeWall had used the wrong billing code, demanded repayment of $60,000.[91] ALJ Byron A. Samuelson found, like the previous ALJ, that DeWall correctly and nonfraudulently sought reimbursement under Code L0430.[92] In 1998, Medicare *again* claimed it overpaid DeWall because DeWall had used the wrong billing code.[93] ALJ Emily Cameron Shattil found DeWall had used the proper code and "further noted that 'DeWall has now established in four separate instances that the proper code is being used, but this has been at the cost of nearly destroying his company . . . this result does not advance the purposes of the Medicare Program.'"[94] Finally, the DeWall appeals process made it to the fifth step in the Part B appeals process—judicial review—when Medicare once again sought repayment from DeWall for using the wrong billing code, L0430.[95] The court found DeWall had used the

83. *DeWall*, 206 F. Supp. 2d at 1001.
84. *Id.* at 998.
85. *Id.*
86. *Id.* at 994 (referring to 42 U.S.C. § 1395u(h) (2006)).
87. *Id.*
88. *Id.*
89. *Id.* at 994-95. DeWall was advised to use Code L0340, which was listed in the Durable Medical Equipment Prosthetics and Suppliers Manual as "a [thoracic-lumbar support orthosis], anterior-posterior-lateral control, with interface material, custom-fitted." *Id.* at 994 (alteration in original) (quoting HCPCS Code L0340) (internal quotation marks omitted). Medicare claimed he should have used Code L0315, "described in the Manual as 'TLSO flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel.'" *Id.* (quoting HCPCS Code L0315).
90. *Id.* at 995.
91. *Id.*
92. *Id.*
93. *Id.* at 996.
94. *Id.* (alterations in original) (quoting Plaintiff's Exhibit 12).
95. *See id.*

proper codes and had properly stated a claim for mandamus relief.[96] The court further noted,

> DeWall has shown irreparable harm. He has shown more than a mere economic injury. . . . DeWall can point to an eleven-year history of the Secretary's recalcitrance in consistently following his own interpretation of his own regulations. At many points in this history, DeWall has been faced with economic ruin injury and the court finds that he should not, once again, be forced to face this specter.[97]

Although Medicare has a duty to prevent fraud and abuse, when ALJs deemed that DeWall's billing procedure was not fraudulent, Medicare continued to claim it had overpaid DeWall because he had used the wrong code.[98] Moreover, Medicare never appealed any decision by the ALJ and, instead, simply did not abide by the ALJ's order to pay DeWall.[99] The court's own words poignantly describe this procedural "gauntlet" faced by DeWall:

> [The supplier] has sought and obtained numerous adjudications in his favor on the *exact issue* now before the court. . . . The Secretary has not challenged the determinations through the appeals process available to it, but has simply ignored the determinations. Under this system, district court review is available only if [the supplier] loses. By failing to appeal adverse decisions, but then refusing to follow the dictates of those decisions, the Secretary has, in practice, denied any judicial review to [the supplier].
>
> . . . . The Secretary admits that there is nothing to prevent the same thing from happening again should [the supplier] follow administrative procedures in connection with any potential claims. [The supplier] is *caught in an endless loop wherein he achieves an illusory victory in administrative proceedings but has no recourse to enforce that victory*.[100]

The rules promulgated by Medicare, as written, insufficiently afforded DeWall due process by essentially denying him judicial review of his claims.[101] By rule, DeWall could only appeal unfavorable decisions by the ALJ, but the ALJs kept rendering decisions in DeWall's favor—the agency refused to abide by those decisions.[102] As a last resort, DeWall sought mandamus relief for an otherwise unreviewable administrative procedure.[103] As the court noted,

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96. *Id.* at 1001.
97. *Id.*
98. *See id.* at 994-96.
99. *Id.* at 998.
100. *Id.* (emphasis added) (footnotes omitted).
101. *See id.*
102. *See id.* at 996; 42 C.F.R. § 405.1100 (2012).
103. *See DeWall*, 206 F. Supp. 2d at 1001 ("DeWall has shown he is caught in the ultimate 'catch 22' and it is up to this court as a last resort to protect such a claimant and to prevent the sort of bureaucratic legerdemain—incompetence at the least and outright trickery at the most—presented in this case.").

however, DeWall had faced financial ruin due to the expense of the appeals process.[104]

When a plaintiff filed a similar action in the District Court for the Northern District of Texas, the district court dismissed the claim for lack of subject matter jurisdiction and for failure to state a claim for mandamus relief.[105] The medical service provider, Randall Wolcott, M.D., P.A. appealed, and the Fifth Circuit issued an opinion that distinguished *DeWall* but did not completely rule out its application to the facts of *Wolcott I*.[106]

2. Wolcott v. Sebelius

Randall Wolcott, M.D., P.A. is a specialist who operates a wound care clinic.[107] Over 90% of his patients are covered by Medicare Part B insurance.[108] Moreover, his practice requires him to control infected wounds through a specialized procedure called debridement.[109] Most patients have preexisting conditions that contributed to the development of chronic wounds, and because of this, the patients are often treated for more than one wound.[110] Wolcott debrides each wound according to the established standard of care.[111] In 2007, Medicare denied 100% of Wolcott's reimbursement claims over a

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104. *Id.*

105. *Wolcott I*, 635 F.3d 757, 760 (5th Cir. 2011).

106. *See id.* at 767 n.3.

107. Interview with Randall D. Wolcott, *supra* note 14. It is important to note that Dr. Wolcott is an internationally renowned expert in the field of chronic wound management, and therefore, his case is particularly troubling in light of his expertise. *Id.* For example, he was featured in *Popular Science* for his work in phage therapy. *See* Elizabeth Svoboda, *The Next Phage*, POPULAR SCI. (Apr. 2009), http://www.popsci.com/scitech/article/2009-03/next-phage?page=1. He has spoken at dozens of international conferences and has published dozens of peer-reviewed articles. *See, e.g.*, Randall D. Wolcott & Garth D. Ehrlich, *Biofilms and Chronic Infections*, 299 J. AM. MED. ASS'N 2682 (2008) (proposing a new paradigm for planktonic, or single-cell, bacteria versus a biofilm community model); Randall D. Wolcott et al., *The Polymicrobial Nature of Biofilm Infection*, 19 CLINICAL MICROBIOLOGY & INFECTION 107 (2013) (co-authoring a proposal with William Costerton, widely regarded as "the father of biofilm," concerning new methods of analyzing polymicrobial infections). Finally, Dr. Wolcott's Southwest Research and Testing Laboratories recently ran bacterial diagnostics on equipment used on NASA's Curiosity Mars rover. Interview with Randall D. Wolcott, *supra* note 14.

108. Interview with Randall D. Wolcott, *supra* note 14.

109. *See Debridement Definition*, SURGERYENCYCLOPEDIA.COM, http://www.surgeryencyclopedia.com/Ce-Fi/Debridement.html (last visited Mar. 18, 2013) ("Debridement is the process of removing dead (necrotic) tissue or foreign material from and around a wound to expose healthy tissue.").

110. Daniel D. Rhoads et al., *Clinical Identification of Bacteria in Human Chronic Wound Infections: Culturing vs. 16S Ribosomal DNA Sequencing*, 12 BMC INFECTIOUS DISEASE 312, 323 (2012), *available at* http://www.biomedcentral.com/content/pdf/1471-2334-12-321.pdf.

111. *See, e.g.*, T. Cowan, *Biofilms and Their Management: From Concept to Clinical Reality*, 20 J. WOUND CARE 220, 222-6 (2011) (praising lectures by two of the world's leading microbiologists whose clinical trials showed 90% healing rates in patients receiving a high number of debridements); S.E. Dowd et al., *Molecular Diagnostics and Personalised Medicine in Wound Care: Assessment of Outcomes*, 20 J. WOUND CARE 232, 243-9 (2011) (recounting a study of three cohorts showing that a molecularly targeted biofilm management strategy coupled with frequent debridement drastically increases healing outcomes for patients and eliminates the need for amputation).

period of six months.[112] On behalf of his patients, Wolcott appealed the denial of thousands of procedures for hundreds of patients.[113] Wolcott, after having followed the appeals process, received favorable decisions from ALJs for over 90% of his claims.[114] Wolcott brought suit because Medicare did not abide by the decisions of the ALJ, just as in the *DeWall* case.[115] Moreover, the provider continued to deny claims for the same exact reasons on nearly identical facts even though ALJs, on numerous occasions, had ruled the procedure was proper.[116]

Wolcott's complaint consisted of five counts, two of which bear on this Comment.[117] First, Wolcott sought an order in mandamus to compel Medicare to reimburse Wolcott for successfully appealed claims.[118] The Fifth Circuit determined that "Wolcott ha[d] sufficiently pleaded that [he] ha[d] a clear right to relief, that the defendants owe a non-discretionary duty to issue payment to Wolcott for appealed claims finally decided in Wolcott's favor, and that no adequate alternative remedies exist."[119] The court then reversed and remanded the decision of the lower court.[120] Although the court stated Wolcott was entitled to mandamus relief for Count I, the court also stated Wolcott could not seek mandamus relief for Count III.[121] In Count III, Wolcott asked that Medicare cease re-denying similar claims for the same patients.[122] Wolcott analogized his situation to *DeWall*.[123] Wolcott claimed that he used the same standard of care for patient debridements and, therefore, Medicare should not be able to deny claims in which the same standard of care was used—just as the *DeWall* court ordered that Medicare could not continue to deny DeWall reimbursement when ALJs had already determined that DeWall's billing code was medically acceptable.[124] Wolcott argued that both cases involved relitigation of identical issues and, therefore, issue preclusion was an appropriate remedy.[125] The court disagreed, stating that *DeWall* involved a "true mandamus action," whereas Wolcott's count was merely "an action for

112. Interview with Bridget Eubanks, *supra* note 24.

113. *Wolcott I*, 635 F.3d 757, 761 (5th Cir. 2011).

114. Randall D. Wolcott, *Biofilm Based Wound Care* 1, 5, 9 (Sept. 17, 2007) (unpublished manuscript) (on file with author).

115. *See Wolcott I*, 635 F.3d at 760; *see also* discussion *infra* Part II.B.1.

116. *Wolcott I* Brief, *supra* note 73, at 6.

117. *Wolcott I*, 635 F.3d at 760.

118. *Id.* at 768.

119. *Id.* at 771.

120. *Id.*

121. *Id.* at 767, 771.

122. *Id.* at 767.

123. *Id.*

124. *Id.*; *see also* Dowd et al., *supra* note 111, at 243-49. For example, the traditional standard of care for normal wound debridement is once per week, but a wound care specialist dealing with a chronic wound might perform twice that amount in an attempt to save a patient's leg. *See id.*

125. *Wolcott I*, 635 F.3d at 767; *cf.* DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 998 (D. Neb. 2002) (granting mandamus when the supplier had "sought and obtained numerous adjudications in his favor on the *exact issue* now before the court." (emphasis added)).

injunctive relief."[126] The court then held that, while it had jurisdiction under the Mandamus and Venue Act to compel payment for unpaid claims, it did not have jurisdiction to grant injunctive relief to compel Medicare to cease re-denying claims for identical issues.[127]

On remand, Wolcott sought to amend his complaint to state that Medicare had still not paid the mandated claims and had further re-denied several of those claims.[128] The district court granted summary judgment against Wolcott before he could file his amended complaint, but this allowed Wolcott to emphasize *DeWall* once again, stating that his only chance of receiving payment was to order Medicare to essentially stop avoiding payments by using the injunctive-relief loophole.[129] This loophole raises the issues of efficiency and fairness in these two cases.[130] When one patient appeals one procedure, the system seems fair and efficient; however, the U.S. Legislature could not have foreseen the current medical context in which specialists, who perform the same procedure every day on multiple patients, would have to go through this long appeals process every single time a procedure is denied.[131] It is not efficient for specialists who frequently perform the same procedure to continuously contest denials of procedures performed in the ordinary course of the specialist's business when that procedure falls within the specialized standard of care though outside the normative standard of care.[132] Moreover, it is not fair for patients or medical service providers when Medicare circumvents payment through procedural loopholes, essentially robbing claimants of their due process rights.[133]

III. MANDAMUS AND MEDICARE

A. The Fifth Circuit Holds Mandamus Jurisdiction Is Not Precluded by 42 U.S.C. § 405(h) of the Social Security Act

One way to close this loophole is through mandamus relief. Although the fifth step of the Medicare Part B appeals process allows a party to seek redress in a federal court, that party must still establish that the district court has subject matter jurisdiction over the party's claims.[134] For the past thirty years, the federal courts have struggled with whether they have jurisdiction over a party's

126. *Wolcott I*, 635 F.3d at 767 n.3.
127. *Id.* at 766.
128. *Wolcott I* Brief, *supra* note 73, at 6.
129. *See* Plaintiff-Appellant's Reply Brief at 8-10, *Wolcott II*, 497 F. App'x 400 (5th Cir. 2012) (No. 12-10010) [hereinafter *Wolcott II* Plaintiff-Appellant's Reply Brief].
130. *Wolcott I*, 635 F.3d at 774; *see DeWall*, 206 F. Supp. 2d at 1001-02.
131. *See Wolcott I*, 635 F.3d at 761.
132. *See* Dowd et al., *supra* note 111, at 243-49.
133. *See* U.S. CONST. amend. V.
134. *See* 42 C.F.R. § 405.1136 (2012); FED. R. CIV. P. 12(h)(3).

mandamus claims.[135] Mandamus, as every first year law student learns in *Marbury v. Madison*, is an extraordinary remedy and is rife with balance-of-power issues.[136] Though the Mandamus and Venue Act established guidelines for mandamus jurisdiction, the Social Security Act expressly forbids any grant of mandamus action over final decisions by the Secretary of Health and Human Services.[137] Because the Social Security Act was made directly applicable to Medicare through the Medicare Act of 1965, this statutory language also prevents a party from bringing a mandamus action against the Secretary of the Department of Health and Human Services.[138]

Wolcott v. Sebelius I allowed the Fifth Circuit to address the issue of mandamus preclusion by 42 U.S.C. § 405(h), on which eleven other circuit courts had already ruled.[139] The majority trend reasoned that mandamus jurisdiction was not precluded for otherwise unreviewable procedures, which, put simply, means that federal courts have mandamus jurisdiction when an appellant has no other avenue to seek review of allegedly deficient administrative procedures.[140] Two circuits (the First and Eleventh) have yet to recognize jurisdiction but have left the issue open.[141] Following the majority trend, the Fifth Circuit held that it had the authority to grant mandamus for otherwise unreviewable administrative procedures.[142] In the aforementioned cases, however, mandamus relief was still difficult to obtain even though the courts found jurisdiction was not precluded.[143] For example, in *Wolcott I*, the court stated that it could not compel an agency official's future actions, and thus, it could not compel Medicare to cease denying claims based on Wolcott's standard of care.[144] Although Medicare stated it reviewed each patient's claim

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135. *See* discussion *infra* Part V.F.

136. *See* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 147-48 (1803).

137. *See* Mandamus and Venue Act of 1967, 28 U.S.C. § 1361 (2011); Social Security Act, 42 U.S.C. § 405(h) (2011).

138. *See* 42 U.S.C. § 1395ii (2011).

139. *See Wolcott I*, 635 F.3d 757, 763-66 (5th Cir. 2011).

140. *See, e.g.*, Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 813 (D.C. Cir. 2001); Cordoba v. Massanari, 256 F.3d 1044, 1047 (10th Cir. 2001); Buchanan v. Apfel, 249 F.3d 485, 491-92 (6th Cir. 2001); U.S. *ex rel*. Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 508-09 (4th Cir. 1999); Briggs v. Sullivan, 886 F.2d 1132 (9th Cir. 1989); Burnett v. Bowen, 830 F.2d 731 (7th Cir. 1987); City of New York v. Heckler, 742 F.2d 729 (2d Cir. 1984); Belles v. Schweiker, 720 F.2d 509 (8th Cir. 1983); Colonial Penn Ins. Co. v. Heckler, 721 F.2d 431 (3d Cir. 1983).

141. Lifestar Ambulance Serv., Inc. v. United States, 365 F.3d 1293, 1295 n.3 (11th Cir. 2004) ("We assume, without deciding, that mandamus jurisdiction is not barred by 42 U.S.C. § 405(h) and, therefore, is available for a claim arising under the Medicare statute."); Matos v. Sec'y of Health, Educ. & Welfare, 581 F.2d 282, 286 n.6 (1st Cir. 1978) ("If a claimant were to raise a new and different claim, and the Secretary were to refuse to act based on *res judicata*, the claimant would be denied all opportunity for a hearing unless judicial review were available. Such a result would contravene the provisions of the Act, whereby affected parties must be given 'reasonable notice and opportunity for a hearing,' and of due process. Our holding does not preclude jurisdiction where a colorable constitutional claim is raised." (citation omitted) (quoting 42 U.S.C. § 405(b))).

142. *See Wolcott I*, 635 F.3d at 764.

143. *See supra* note 140 for a comprehensive list of cases.

144. *See Wolcott I*, 635 F.3d at 766.

to see if treatment was medically reasonable and necessary, it really denied claims because it found the *standard of care* was not reasonable or necessary.[145] The court, however, decided this was a different, future issue and not the same, past issue.[146] The Supreme Court has long referred to mandamus as an "extraordinary remedy," and a brief examination of mandamus is particularly helpful in framing why courts are so hesitant to grant mandamus relief.[147]

B. Mandamus's "Extraordinary" History[148]

All of the federal circuit courts have now had an opportunity to address mandamus jurisdiction in the context of 42 U.S.C. § 405(h).[149] In the seminal case of *Cheney v. U.S. District Court for D.C.*, the Court stated that mandamus is only appropriate for cases with "exceptional circumstances amounting to a judicial usurpation of power or a 'clear abuse of discretion.'"[150] Because mandamus is such an extraordinary measure, a plaintiff must establish three elements in order to qualify for relief.[151] First, the plaintiff must establish he has a clear right to relief.[152] In *Will v. United States*, the Supreme Court stated, "[T]he party seeking mandamus has 'the burden of showing that its right to issuance of the writ is clear and indisputable.'"[153] Second, he must establish that the defendant has a clear duty to act.[154] Finally, he must establish that there is no other available remedy.[155] When reviewing mandamus jurisdiction, courts tend to focus on the third element—that the plaintiff has no other available remedy.[156]

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145. *See* Wolcott, *supra* note 114, at 5.

146. *See Wolcott I*, 635 F.3d at 767 n.3.

147. *See* Cheney v. U.S. Dist. Court for D.C., 542 U.S. 367, 380 (2004); *see also* discussion *infra* Part IV.

148. *See generally* Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803) (holding that a writ of mandamus is the correct judicial method to order a government official to act).

149. *See, e.g.*, Lifestar Ambulance Serv., Inc. v. United States, 365 F.3d 1293, 1295 n.3 (11th Cir. 2004); Matos v. Sec'y of Health, Educ. & Welfare, 581 F.2d 282, 286 n.6 (1st Cir. 1978); *see also supra* note 140 for a comprehensive list of cases.

150. *Cheney*, 542 U.S. at 380 (citation omitted) (quoting Bankers Life & Cas. Co. v. Holland, 346 U.S. 379, 383 (1953)).

151. *See* Jones v. Alexander, 609 F.2d 778, 781 (5th Cir. 1980).

152. *See id.*

153. Will v. United States, 389 U.S. 90, 96 (1967) (quoting *Bankers Life*, 346 U.S. at 384) (internal quotation marks omitted).

154. *See Jones*, 609 F.2d at 781.

155. *See id.*

156. *See Wolcott I*, 635 F.3d 757, 768 (5th Cir. 2011).

IV. JUDICIAL REVIEW OF MEDICARE ADMINISTRATIVE HEARINGS

A. Judicial Review Redux

Although case law about judicial review of specific Medicare appeals is sparse, the fifth step of the Medicare appeals process fits into the broader category of administrative law dealing with judicial review of administrative hearings. Traditionally, courts are very deferential to the decisions of the agency because the agency is more specialized; for example, Medicare has the resources and knowledge to understand reasonable medical necessity better than a judge or justice who has no specialized training in medicine.[157] Still, the Administrative Procedure Act (APA) creates a presumption that agency decisions are available for judicial review.[158] Two exceptions can overcome this presumption.[159] First, a statute can preclude judicial review.[160] Second, a court cannot review "agency action . . . committed to agency discretion by law."[161] Although the Office of Medicare Hearings and Appeals explicitly states that unfavorable decisions may be appealed to a federal court, this does not mean that judicial review is automatically available for all appeals concerning the agency.[162] The Office of Medicare Hearings and Appeals only provides for one who *disagrees* with the MAC decision to seek redress in a federal court.[163] The department is silent as to what process is afforded to a provider who is satisfied with the previous decisions but who has yet to be paid for his claims.[164] The *DeWall* court offered its own solution to the agency's silence by granting mandamus relief for the provider who was happy with his level four appeal but was unhappy that he had not been paid.[165] The plaintiff in *Wolcott v. Sebelius* also sought to cure this defect through mandamus relief.[166] Medicare protested in *Wolcott I*, however, that Wolcott's claims were not only precluded by statute in the agency's enabling act but also precluded by statute because Medicare's actions were discretionary by law.[167] Nevertheless, in its first decision in *Wolcott I*, the Fifth Circuit remanded portions of the case to see

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157. *See* Rogers, *supra* note 34, at 104 (emphasizing the tendency of courts to "give great deference to the Secretary's interpretation of its reimbursement regulations because of the specific medical expertise needed to make such determinations").

158. *See* Administrative Procedure Act, 5 U.S.C. § 701 (2011).

159. § 701(a)(1)-(2).

160. § 701.

161. § 701(a)(1)-(2). *See generally* Ronald M. Levin, *Understanding Unreviewability in Administrative Law*, 74 MINN. L. REV. 689 (1990) (offering an in-depth background of the complications of what actions are and are not reviewable by an Article III court).

162. *See OMHA Level 5 Appeals*, supra note 61.

163. *Id.*

164. *See id.*; *see also* discussion *supra* Part II.B.1-2.

165. *See* Dewall Enters. Inc. v. Thompson, 206 F. Supp. 2d 992, 994 (D. Neb. 2002).

166. *See Wolcott I*, 635 F.3d 757, 764 (5th Cir. 2011).

167. *See* Brief of Defendant-Appellee at 28, *Wolcott II*, 497 F. App'x 400 (5th Cir. 2012) (No. 12-10010) [hereinafter *Wolcott II* Defendant-Appellee's Brief] (referencing the Administrative Procedure Act, 5 U.S.C. § 701 (2011)).

if there were still outstanding claims that Medicare had not reimbursed.[168] If those claims still remained unpaid, the Fifth Circuit ordered the district court to exercise its power of judicial review and examine whether mandamus relief was appropriate under the given circumstances.[169]

B. Two Views of Issue Preclusion

Medicare's main argument against any mandamus action ordering Medicare to pay a provider and forbidding Medicare from re-denying claims that an ALJ or MAC has already held to be "reasonable and necessary" is that the ALJ's decision would have the effect of stare decisis—a concept not typically applied in administrative law.[170] In *Universal Camera Corp. v. NLRB*, the Supreme Court discussed the weight of an ALJ's decision.[171] Justice Frankfurter, while recognizing the need for an agency to have flexibility in its intra-agency review process, also noted that the ALJ presided over the evidentiary hearing, heard witnesses, and reviewed the entire record.[172] *Universal Camera* emphasized the depth and breadth of time and expertise that an ALJ must devote to issuing his order.[173] These final decisions by an ALJ, though given weight by federal courts in the context of judicial review, do not have the same impact on an agency that will have discretion to decide whether to apply this rule in future proceedings.[174] Most surely, agency adjudications do not have the effect of stare decisis.[175] Indeed, the Fifth Circuit decried, "An agency . . . is not bound by the shackles of stare decisis to follow blindly the interpretations that it, or the courts of appeals, have adopted in the past."[176] Issue preclusion, on the other hand, is not a foreign concept in administrative law.[177] Issue preclusion exists in the administrative context, but ALJs and judges usually apply it flexibly.[178] Parties are often precluded from relitigating the same issue in administrative adjudicatory proceedings.[179] An examination of case law, however, reveals that the common law doctrine of issue preclusion does not always function the same way in administrative proceedings.[180] Issue

168. *See Wolcott I*, 635 F.3d at 773.

169. *See id.*

170. *See Wolcott II* Defendant-Appellee's Brief, *supra* note 167, at 28.

171. Universal Camera Corp. v. NLRB, 340 U.S. 474, 475 (1951).

172. *Id.*

173. *Id.*

174. *See* KOCH, *supra* note 34, § 5.70, at 287-92.

175. *See id.* § 5.72, at 304.

176. *See* Texas v. United States, 866 F.2d 1546, 1556-57 (5th Cir. 1989).

177. *See* 2 RICHARD PIERCE, ADMINISTRATIVE LAW TREATISE § 13.4, at 1145 (5th ed. 2010) ("Collateral estoppel, or issue preclusion . . . prevents a second litigation of the same issues even in connection with a different claim or cause of action.").

178. *See Collateral Consequences of an Administrative Decision—Basic Principles*, 7 WEST'S FED. ADMIN. PRAC. § 7867 (3d ed. 2012).

179. *See* PIERCE, *supra* note 177, § 13.4, at 1145 ("Courts routinely apply collateral estoppel to issues resolved by agencies, but a few added complexities arise in the agency context.").

180. *See generally id*. § 13.5, at 1155-60 (surveying the case law of collateral estoppel when the

preclusion seems to function against whether the *agency* may relitigate an issue at its own discretion or whether relitigation would be unfair to the defending party, who may or may not have had an opportunity to defend himself.[181] Basically, the intent of the APA is to protect the agency from having to relitigate claims for the sake of efficiency.[182] Additionally, the Act sets forth an alternative goal that the "agency should not be precluded from relitigating factual questions, especially those involving expert judgment, because of a determination made in a different agency proceeding."[183] This language essentially gives agencies unfettered power to relitigate a factual determination from another proceeding.[184] But the Act does not answer how frequently the agency may relitigate those factual determinations.[185] In cases such as *DeWall* and *Wolcott I*, the agency not only never paid the providers pursuant to the administrative rulings but also continued to relitigate those claims in the form of ceaseless denials.[186] At some point, we must draw the line in our system of jurisprudence that defines when an agency has simply gone too far. The following solutions provide some guidance.[187]

V. JUDICIALLY CREATED REMEDY: A GRANT OF MANDAMUS ORDERING ISSUE PRECLUSION

A. Inaction Speaks Louder Than Words: The Fifth Circuit Adopts Mandamus Jurisdiction but Hesitates to Apply It

Mandamus is currently the only option medical service providers have to prevent an agency from continuously re-denying similar claims.[188] The Fifth Circuit would have been the first federal circuit court to expressly rule on the issue of mandamus, thus providing guidance to other circuit courts.[189] Although the Fifth Circuit adopted mandamus jurisdiction in *Wolcott I*, it balked at the opportunity to grant it.[190] On October 17, 2012, the Fifth Circuit rendered its final decision in the *Wolcott v. Sebelius* line of cases and stated that Wolcott's mandamus claim was moot.[191] The court failed to reach the issue of mandating issue preclusion as *DeWall* had done, even though the case had been

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government is a party).

181. *See id*. § 5.72, at 304.

182. *See id.*

183. *See id.*

184. *See id.*

185. *See supra* text accompanying notes 158-61.

186. *See Wolcott I*, 635 F.3d 757, 770 (5th Cir. 2011); DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 998 (D. Neb. 2002).

187. *See* discussion *infra* Parts V-VII.

188. *See infra* text accompanying note 220.

189. *See infra* text accompanying note 219.

190. *See Wolcott I*, 635 F.3d at 768; *Wolcott II*, 497 F. App'x 400, 406 (5th Cir. 2012) (per curiam).

191. *Wolcott II*, 497 F. App'x at 402.

central in both the appellant's and appellee's briefs.[192] The Fifth Circuit emphasized that mandamus is an extraordinary remedy that must be supported by a clear right to relief, and then, like Justice Marshall in *Marbury*, the panel creatively justified how Wolcott had failed to meet its burden.[193]

Several factors indicate the court did not want to reach the issue of mandamus. First, the court dismissed the case solely on the issue of whether Wolcott timely filed a motion for summary judgment.[194] The district court judge gave the following order to both parties:

> If the relief requested in Count I has become moot since the filing of Plaintiff's Complaint, the parties should notify the Court promptly. In the event a dispute remains, motions for summary judgment on Count I should be filed on or before 3:00 p.m. on November 4, 2011, with any responses due 21 days after the filing of the motions.[195]

In his brief, Wolcott argued that the case had not become moot, thus relieving him of his duty to respond to the first request of the court.[196] In response to the court's second order, Wolcott stated that he could not file a summary judgment motion because he believed disputed facts existed and that, therefore, his attorney could not file a summary judgment motion in good faith pursuant to Federal Rule of Civil Procedure 11.[197] Wolcott did, however, file "motions for issuance of a scheduling order to allow discovery and for leave to file an amended complaint."[198] Moreover, when the defendant filed a motion for summary judgment, summary judgment was granted before the prescribed time had elapsed for Wolcott to file a response to summary judgment.[199] The decision seems contrary to the Federal Rules of Civil Procedure, and certain justices seemed to think during oral arguments that filing a summary judgment motion was mandatory.[200]

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192. *See Wolcott II* Plaintiff-Appellant's Reply Brief, *supra* note 129, at 8-10; *Wolcott II* Defendant-Appellee's Brief, *supra* note 167, at 28-31. One might also speculate that the potentially precedential *DeWall* issue was the reason the Fifth Circuit granted oral arguments in the first place.

193. *Wolcott II*, 497 F. App'x at 406-08 (citing Giddings v. Chandler, 979 F.2d 1104, 1108 (5th Cir. 1992)). *See generally* Dean Alfange, Jr., Marbury v. Madison *and Original Understandings of Judicial Review: In Defense of Traditional Wisdom*, 1993 SUP. CT. REV. 329, 330 (discussing the historical implications of Justice Marshall's equivocal holding).

194. *See Wolcott II*, 497 F. App'x at 406-08.

195. *Id*. at 403.

196. *See Wolcott II* Plaintiff-Appellant's Reply Brief, *supra* note 129, at 2.

197. *See id.*; FED. R. CIV. P. 56 ("The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law."); FED. R. CIV. P. 11(b) ("By presenting to the court a pleading, written motion, or other paper—whether by signing, filing, submitting, or later advocating it—an attorney or unrepresented party certifies that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances . . . .").

198. *Wolcott II* Plaintiff-Appellant's Reply Brief, *supra* note 129, at 3.

199. *See id.*

200. Oral Argument at 36:14, Wolcott v. Sebelius, No. 12-10010, 2012 WL 4902870 (5th Cir. 2012), *available at* http://www.ca5.uscourts.gov/OralArgRecordings/12/12-10010_9-5-2012.wma.

Perhaps this potential conflict with the Federal Rules of Civil Procedure is why the court determined that the opinion should not be published, pursuant to the Fifth Circuit's Rule 47.5.[201] The court could have invoked Rule 47.5 for multiple reasons.[202] For example, the Fifth Circuit has historically employed Rule 47.5 when a matter was resolved solely on mundane procedural issues, which could be the case here.[203] Because all opinions are now published online and Rule 47.5 was codified before the advent of Westlaw and LexisNexis, some scholars have speculated that the rule is used to dissuade other courts from relying on information that may not be completely consistent with Texas law, which could also be applicable to the case at bar.[204] Additionally, the opinion was explicitly designated as nonprecedential, which underscores the theory that the court may not have been completely confident in its summary judgment analysis.[205] Finally, the per curiam opinion may indicate that none of the justices wanted to take credit for an opinion that may have misinterpreted the Federal Rules of Civil Procedure.[206]

This circumvention of a discussion of mandamus in *Wolcott II*, coupled with the Fifth Circuit's characterization of Wolcott's mandamus claim for issue preclusion in *Wolcott I* as future injunctive relief, signifies that the Fifth Circuit, and courts in general, err on the side of caution when choosing whether to grant mandamus.[207] A mandamus action seeking interference with agency action merely exacerbates this cautionary behavior, but courts *should* grant mandamus in situations like *DeWall* and *Wolcott I* and *II* when the court is the last resort in closing an unfair administrative loophole—which falls outside the bounds of agency discretion and decision making.[208]

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201. *Wolcott II*, 497 F. App'x 400, 401 (5th Cir. 2012) (per curiam); 5TH CIR. R. 47.5, *available at* http://www.ca5.uscourts.gov/clerk/docs/5thCir-IOP.pdf (stating that "well-settled principles of law," strictly procedural issues, or cases that judges think unjustified for publication under the guidelines need not be published).

202. *See generally* James W. Paulsen & Gregory S. Coleman, *Civil Procedure*, 26 TEX. TECH L. REV. 397 (1995) (analyzing the Federal Rules of Civil Procedure as applied by the Fifth Circuit).

203. *See id.* at 439-40.

204. *See id.* at 440. For example, many opinions appear in the *Federal Appendix*, West Publishing's database of otherwise "unpublished" opinions. *See id.*

205. *See id.*

206. *See Wolcott II*, 497 F. App'x at 401; *see also* Ira P. Robbins, *Hiding Behind the Cloak of Invisibility: The Supreme Court and Per Curiam Opinions*, 86 TUL. L. REV. 1197, 1241-42 (2012) (positing that per curiam opinions are too often used to shield justices from being held accountable for unfavorable opinions).

207. *See Wolcott I*, 635 F.3d 757, 767 n.3 (5th Cir. 2011). The D.C. Circuit seems to be the only court comfortable with interfering with agency action, and scholars have come to consider the D.C. Circuit as a specialist in administrative law. *See* CHRISTOPHER P. BANKS, JUDICIAL POLITICS IN THE D.C. CIRCUIT COURT 132 (1999).

208. *See* discussion *infra* Part V.B.

B. Dispelling the Myth: Issue Preclusion Does Not Interfere with Agency Decision Making

The common threads connecting *Wolcott* and *DeWall* are whether the court may grant mandamus to preclude relitigating an issue that has already been resolved in a previous adjudication and whether using this method to cure a procedural defect within the Medicare appeals process is within the court's discretion.[209] The Fifth Circuit did not grant mandamus in *Wolcott II*, and it is not the first court to hesitate to do so.[210] Many courts adopting mandamus jurisdiction have scarcely granted writs of mandamus to parties seeking mandamus relief.[211] The D.C. Circuit, however, has been the most active court in affirming grants of mandamus relief.[212] For example, even though ten of twelve circuits have adopted mandamus jurisdiction, no federal circuit court has granted mandamus—and the *DeWall* court has been the only district court to grant mandamus.[213] Part of this hesitance to grant mandamus relief is because of the underlying deference that judges are encouraged to give agencies because agency officials possess greater expertise in their respective areas.[214] Recall in *Marbury v. Madison* that many critics praised Justice Marshall's decision because although he held that mandamus jurisdiction existed, he did not grant mandamus relief, thus avoiding any political complications for granting mandamus.[215] The default for judicial review is deference to an administrative agency's discretion.[216] Agencies are supposed to occupy a sphere of specialization that is hard for the federal courts to adjudicate because agencies have specialized knowledge in very specific fields of practice.[217] In the rare case in which the court grants mandamus relief, the federal court has directly reviewed the otherwise unreviewable procedural issues brought about by the administrative appeals process itself.[218] In other words, the court is examining

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209. *See supra* text accompanying note 207.

210. *See Wolcott I*, 635 F.3d at 768; *Wolcott II*, 497 F. App'x at 407-08; *see also supra* note 140 (providing a comprehensive list of cases).

211. *See supra* note 140 for a comprehensive list of cases.

212. *See, e.g.*, *In re* Medicare Reimbursement Litig., 414 F.3d 7, 13 (D.C. Cir. 2005) (affirming the district court's grant of mandamus relief); Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 808 (D.C. Cir. 2001) (holding that the plaintiff was entitled to mandamus relief); U.S. *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 515 (4th Cir. 1999) (affirming the district court's grant of writ of mandamus relief); Ganem v. Heckler, 746 F.2d 844, 855 (D.C. Cir. 1984) (holding that the district court should grant a writ of mandamus).

213. *See supra* note 140 for a comprehensive list of cases.

214. *See* Rogers, *supra* note 34, at 104.

215. *See* Alfange, *supra* note 193, at 330.

216. *See* Administrative Procedure Act, 5 U.S.C. § 706 (2011); Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 405 (1971).

217. *See, e.g.*, Colin F. Camerer & Eric J. Johnson, *The Process-Performance Paradox in Expert Judgment: How Can Experts Know So Much and Predict So Badly?*, *in* TOWARDS A GENERAL THEORY OF EXPERTISE: PROSPECTS AND LIMITS 195 (1991) (K. Anders Ericsson & Jacqui Smith eds., 1991).

218. *See, e.g.*, *In re* Medicare Reimbursement Litig., 414 F.3d 7, 13 (D.C. Cir. 2005) (affirming the district court's grant of mandamus); Monmouth Med. Ctr. v. Thompson, 257 F.3d 807, 808 (D.C. Cir. 2001) (holding that the plaintiff was entitled to mandamus relief); Rahman v. Oncology Assocs., P.C., 198 F.3d 502,

the procedure as interpreted by the ALJs, the MAC, etc.[219] The holdings have only had practical, limited effects—the decisions do not bind the parties in subsequent disputes, nor is the agency bound to apply that rule in future adjudications with different parties.[220] The plaintiff-appellant in *Wolcott I* and *II* questions whether it is a constitutional deprivation of due process to allow an agency to continue to litigate identical issues between the same parties.[221]

The Fifth Circuit may have avoided mandamus and issue preclusion because it feared it would overstep the bounds of deference by dictating how adjudications should function at the ALJ level and would interfere with the discretionary power of the agency.[222] Although a grant of mandamus would not have the effect of stare decisis, contrary to Medicare's contentions, the grant of mandamus would potentially set the precedent that issue preclusion should exist between a party and the agency, thus changing the current administrative adjudicatory structure within Medicare.[223] Unfortunately, this is currently the *only* remedy available to medical service providers because no other judicially or congressionally created remedy exists; thus far, only the Nebraska District Court in *DeWall v. Thompson* has granted mandamus relief to a medical service provider who consistently received favorable decisions from the Medicare ALJs but still faced unending denials or remained unreimbursed by the agency.[224] The case has no subsequent history, and DeWall has not sought judicial review of subsequent claims since 2002.[225] This inaction indicates that the mandamus action effectively stopped the cycle of denials faced by DeWall. No sources indicate that the agency felt this ruling changed its policies. Although *DeWall* is a small sample size, courts should be less hesitant to grant mandamus relief for medical service providers who cannot recover on favorable decisions from ALJs.

In its brief for *Wolcott II*, Medicare vehemently urged that ordering the agency to be bound by administrative law decisions would essentially eliminate case-by-case evaluations of procedures that are medically reasonable and

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515 (4th Cir. 1999) (affirming the district court's grant of writ of mandamus); Ganem v. Heckler, 746 F.2d 844, 855 (D.C. Cir. 1984) (holding that the district court should grant a writ of mandamus).

219. *See In re Medicare Reimbursement Litig.*, 414 F.3d at 13; *Thompson*, 257 F.3d at 808; *Oncology Assocs.*, 198 F.3d at 515; *Ganem*, 746 F.2d at 855.

220. *See* SEC v. Chenery Corp., 332 U.S. 194, 198 (1947).

221. *See Wolcott I*, 635 F.3d 757, 760 (5th Cir. 2011).

222. *See* Administrative Procedure Act, 5 U.S.C. § 701(a) (2011) (codifying the application of judicial review to administrative decisions "except to the extent that . . . agency action is committed to agency discretion by law"). *See generally* Harvey Saferstein, *Nonreviewability: A Functional Analysis of "Committed to Agency Discretion,"* 82 HARV. L. REV. 367, 368 (1968) (discussing the trouble courts have had applying the "committed to agency discretion" guideline (quoting 5 U.S.C. § 701(a)(2))).

223. *See Wolcott II* Defendant-Appellee's Brief, *supra* note 167, at 28.

224. *See* DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 994 (D. Neb. 2002). Other courts, including the Fifth Circuit, have characterized relief as injunctive if the facts are not specific enough to *DeWall* (i.e., medical device coding). *See, e.g., Wolcott I*, 635 F.3d at 760.

225. *See DeWall*, 206 F. Supp. at 994 (noting that no other claims were filed after 2002, indicating no subsequent history).

necessary.[226] To support this point, Medicare cited a response to a comment on the Final Rule to Changes in the Medicare Claim Appeals Procedure:

> [I]n some instances, it would be inappropriate to require other adjudicators to afford substantial deference to ALJ decisions . . . [;] the coverage and liability determinations made on claims submitted for treatment are largely unique to the specific facts and circumstances of a given case. Thus, it would prove extremely difficult to identify a set of decisions that could be appropriately afforded deference.[227]

Agencies do need the flexibility to use their specialized areas of knowledge and superior resources to formulate policies and procedures that are consistent with the goals of the agency.[228] Certainly, ALJs who review these highly specialized medical claims do not have the same level of resources or expertise as the agency itself.[229] In a specialized area such as wound care, the agency deserves the utmost deference because of its specialization unless the adjudicators in the appeals process were also medically trained professionals in that specific area.[230] If the majority of adjudicators, however, at different levels of the appeal and across separate appeals processes all determine that Medicare's constant denials of the same claims should be reimbursed, then fairness ought to trump the case-by-case discretion of the agency.[231]

At this point, the agency should re-evaluate its descriptions of reasonable and necessary procedures or devices and should make sure that the agency's definitions are current with the medical community's prescribed standard of care.[232] In other words, the agency should consider these favorable decisions to the service provider as an indication that the agency's policies might be outdated.[233]

VI. CONGRESSIONALLY CREATED REMEDY: A STATUTORY CAUSE OF ACTION

To curb the courts' hesitance to interfere with agency discretion, Congress can intervene by passing a statute that allows federal courts to rely on statutory language and congressional intent to enforce ALJ decisions against Medicare

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226. *Wolcott II* Defendant-Appellee's Brief, *supra* note 167, at 28-33.

227. *See id.* at 31 (alteration in original) (emphasis omitted) (quoting Changes to the Medicare Claims Appeal Procedures, 74 Fed. Reg. 65,296, 65,327 (Dec. 9, 2009)).

228. *See* Charles H. Koch, Jr., *Judicial Review of Administrative Discretion*, 54 GEO. WASH. L. REV. 469, 470 (1986).

229. *See id.*

230. *See id.*

231. *See* DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 1001 (D. Neb. 2002).

232. *See* Dowd et al., *supra* note 111, at 243-49.

233. *See* discussion *infra* Part VII. Medical-expert testimony not only would inform the agency at lower levels of appeal but also could help guide policy changes regarding medical necessity for specialized and quickly advancing fields of medicine. *See* discussion *infra* Part VII.

and to prevent Medicare from continuing to re-deny claims for high-volume medical service providers. A court would not need to issue mandamus if a statute existed that stated that Medicare ought to pay medical service providers when an ALJ or MAC ruled that the reimbursement was properly filed and was medically necessary. In the administrative setting, courts traditionally apply a two-step deference standard derived from *Chevron*.[234] Under this standard, courts first look to whether Congress has explicitly spoken to the specific issue.[235] If so, then the courts owe deference to Congress rather than to the agency, but if Congress created a statute that specifically stated that Medicare is precluded from re-denying similar claims based on a standard of care that an ALJ has already deemed medically reasonable and necessary, then a court might be more comfortable enforcing payment—especially because mandamus would no longer be involved.[236] For example,

> The agency shall be precluded from denying claims by the same claimant if an Administrative Law Judge or Medicare Appeals Council, whichever adjudicator issued the final order of the appeal
>
> - has previously determined the code used by the claimant for the procedure or device is accurate; or
> - has previously determined the standard of care utilized by the medical service provider was medically reasonable and necessary under existing medical practice.

Another provision that Congress should create is the right of the successful party to recover attorneys' fees. For example,

> A federal court may, by rule or regulation, prescribe the maximum fees [that] may be charged for services performed in connection with any claim before a federal court as part of the appeals process, and any agreement in violation of such rules and regulations shall be void. Whenever the court, in any claim before it for reimbursement under this subchapter, makes a determination favorable to the claimant, the court 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.[237]

Some may argue that the availability of attorneys' fees could lead to an influx of frivolous claims.[238] Currently, the appeals process is not cost-effective for a

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234. *See* Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 842-44 (1984).

235. *See id.* at 842-43.

236. *See id.* at 843.

237. *See* 42 U.S.C. § 406(a)(1) (2010). This model statute is based almost entirely on § 406(a)(1) statute regarding the Social Security Administration with certain actors renamed. *See id.*

238. *See* Seann M. Frazier, *Award of Attorneys' Fees in Administrative Litigation*, 69 FLA. B.J., July/August, 1995, at 74, 74 (discussing the problem of meritless claims in administrative litigation).

medical service provider.[239] For example, contesting the denial of one thousand procedures that are reimbursed at a rate of $35 per procedure would not be worth the attorneys' fees incurred in contesting the claim.[240] Allowing for the recovery of attorneys' fees might encourage more medical service providers to follow the appeals process to the level of judicial review, but only those providers who truly believed their claims were valid would risk the substantial cost of litigation.[241] Few medical service providers have the resources to litigate their claims solely on principle—Dr. Wolcott only sought judicial review because he was desperately trying to save his medical practice from financial ruin.[242]

The sanction of attorneys' fees is typically utilized to deter a party from bringing an unsubstantiated claim, but Medicare does not bring claims—it approves or denies them.[243] Awarding the recovery attorneys' fees, on its own, might not deter Medicare from targeting high-volume medical service providers with valid claims, but it seems that reaching the fifth level of the appeals process (judicial review) is a sufficient, albeit slow, deterrent.[244] One provision that would be most likely to deter Medicare would be allowing the recovery of treble damages when a medical service provider succeeds in court.[245] Currently, this solution does not exist in any administrative setting; however, many agencies allow the award of attorneys' fees to prevailing parties and provide an excellent model that Medicare could easily adopt.[246]

VII. ADMINISTRATIVELY CREATED REMEDY: INDEPENDENT MEDICAL EXPERT ADVISERS

Although Medicare is an agency that specializes in health and medicine, the Medicare appeals process calls on individuals to determine whether the Secretary of Health and Human Services accurately denied reimbursement claims because the claimant did not fit a specific medical classification or a

239. *See* DeWall Enters., Inc. v. Thompson, 206 F. Supp. 2d 992, 993 (D. Neb. 2002) (noting that DeWall had faced financial ruin during the course of his appeal); Interview with Randall D. Wolcott, *supra* note 14 (disclosing that Wolcott spent nearly half a million dollars litigating the recovery of $750,000 of reimbursement).

240. *See* Interview with Randall D. Wolcott, *supra* note 14.

241. *Cf.* Frazier, *supra* note 238, at 74 (discussing the problem of meritless claims in administrative legislation).

242. *See* Interview with Randall D. Wolcott, *supra* note 14.

243. *Cf.* Frazier, *supra* note 238, at 74 (discussing the problem of meritless claims in administrative legislation).

244. *See* Interview with Randall D. Wolcott, *supra* note 14 (describing how the denials slowed significantly when he sought judicial review of his claims).

245. Interview with JT Kelley, Att'y, J.T. Kelley Law Firm, P.C., in Lubbock, Tex. (Nov. 20, 2012).

246. *See, e.g.*, 29 U.S.C. § 794a (2010) (regarding attorneys' fees for suits involving violations of § 505(b) of the Rehabilitation Act of 1973); 33 U.S.C. § 1365(d) (2011) (authorizing attorneys' fees for successful claimants under § 505(d) or § 509(b)(3) of the Clean Water Act); Lynn E. Szymoniak, *Recovering Attorney's Fees for Federal Court Representation of Social Security Disability Clients*, 18 SOC. SEC. REP. SERV. 973, 974 (1987) (discussing the award of attorneys' fees for prevailing parties).

medical procedure was not medically reasonable or necessary.[247] In a specialized area such as this, the agency deserves the utmost deference because of its specialization unless, per happenstance, the adjudicators in the appeals process were also medically trained professionals in that *specific* area.[248] The most effective tool to prevent expensive litigation costs, to ensure fairness for medical service providers, and to deliver adequate care to patients is to use medical expert advisers during the Medicare appeals process, which is partly why the Social Security Administration chooses to use vocational experts at its ALJ appeals level.[249] The Social Security Administration provides the best example of expert advisor utilization during its appeals process. When appeals reach the ALJ level for Social Security claims, an expert is usually present.[250] This vocational expert advises the court about whether the claimant's disability would or would not prevent her from participating in the workforce.[251] For example, one judge had to determine if a social security applicant was truly disabled due to "brain trauma caused by athletics, including chronic traumatic encephalopathy" or if he merely suffered postconcussive headaches.[252] A judge who moonlighted as a brain surgeon might be more confident to conclude the Secretary had improperly concluded that the patient did suffer from "chronic traumatic encephalopathy," but a general practitioner may not be so comfortable.[253] Accordingly, the Social Security Administration has tried to solve this problem through the use of an expert.[254]

Certainly, it would be inefficient to provide medical experts for every ALJ hearing.[255] Adjudicators would need different medical experts for the different specializations of medicine that reached the ALJ, and medical experts would undoubtedly be more costly than the vocational experts used by the Social Security Administration.[256] The proper balance would be to allow an ALJ to

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247. *See* 42 C.F.R. §§ 405.920-.1140 (2012).

248. *See* Koch, *supra* note 228, at 470.

249. *See* John J. Capowski, *Accuracy and Consistency in Categorical Decision-Making: A Study of Social Security's Medical-Vocational Guidelines-Two Birds with One Stone or Pigeon-Holing Claimants?*, 3 SOC. SEC. REP. SERV. 1187, 1196-97 (1984).

250. *See Social Security Administration: Hearing Before the H. Ways and Means Subcomm. on Soc. Sec.*, 112th Cong. (2012) (statement of Michael J. Astrue, Comm'r of the Social Security Administration) [hereinafter *Social Security Administration Hearing*], *available at* http://www.ssa.gov/legislation/testimony_062712.html.

251. *See id.*

252. *See* Atkins v. Bert Bell/Pete Rozelle NFL Player Retirement Plan, 694 F.3d 557, 562-63 (5th Cir. 2012). *See generally* H. DUBROFF, THE UNITED STATES TAX COURT: AN HISTORICAL ANALYSIS 184 (1979) (providing a thorough account of the establishment of the United States Tax Court).

253. *Atkins*, 694 F.3d at 562-63.

254. *See Social Security Administration Hearing*, *supra* note 250.

255. *Cf.* R. Michael Booker, *A Guide to the Effective Use of Vocational Experts in Social Security Disability Hearings*, 9 AM. J. TRIAL ADVOC. 237, 238 (1985) (explaining that ALJs may often choose when to call a vocational expert).

256. *See Medical Expert Cost*, COCHRAN FIRM, http://www.cochranfirm.com/resources/Medmal/expertcost.htm (last visited Nov. 28, 2012) ("Most medical experts charge between $350.00-$500.00 per hour to assist with the case. If a medical expert is to be used at trial, the rates go even higher. Some experts charge $2,500-$4,000 per day for travel and testimony time.").

retain a medical specialist to advise the court when the medical service provider has appealed similar claims before and the field seems to be one of specialized medicine in a quickly advancing field.[257] The Social Security Administration uses the vocational-expert test to "explain[] the vocational factors at work in a disability case and . . . respond[] to hypothetical questions posed by the administrative law judge and the disability claimant's attorney."[258] Perhaps the determination of a specific minimum number of appeals is unnecessary and should be left to the discretion of the ALJ (like it is in the Social Security Administration), but certainly, a medical service provider who has appealed a high number of identical or sufficiently similar claims needs some sort of specialized attention by the court to make sure everyone understands the medical reasons behind the procedures.[259]

Practitioners and ALJs both agree that independent expert testimony aids ALJs in understanding some of the more complex issues of specialized areas of Social Security claims, and it follows that expert testimony would create greater understanding and accuracy in an ALJ's determination of medically reasonable necessity.[260] Moreover, this would ensure that patients receive adequate care from the specialists who possess the necessary skills to treat patient illness or injuries. For example, when a physician like Dr. Wolcott is told he can only do five debridements, he is faced with a bleak choice.[261] First, he can continue to treat the patient and appeal the treatments even though he knows the sixth treatment and following will not be reimbursed.[262] He cannot offer services at a discount, nor can Medicare patients choose to pay for the services out of pocket.[263] Medicare believes discounted services are against public policy because doctors might induce patients to spend their money on unnecessary or fraudulent procedures.[264] The policy is a sound one in theory, but when Medicare regulations do not keep up with changes in specialized standards of care, the policy ends up hurting patients. Dr. Wolcott's second choice is to simply stop at the fifth debridement, which, sadly, many physicians choose to do.[265]

Experts are needed not only to reduce the number of appeals that high-volume medical service providers send through the appeals process, but also to ensure that Medicare patient care is not restricted by outdated regulations.[266] A

257. *Cf.* Booker, *supra* note 255, at 237 (discussing the discretion of ALJs to request an expert during social security disability appeals).

258. *Id.*

259. *See* Capowski, *supra* note 249, at 1198.

260. *See* Booker, *supra* note 255, at 237.

261. *See* Interview with Randall D. Wolcott, *supra* note 14.

262. *See id.*

263. Interview with JT Kelley, *supra* note 245.

264. *See id.*

265. *See id.* In our interview, Mr. Kelley, a personal injury lawyer, lamented the choice that many doctors make to choose the bottom line over adequate patient care because the cost of appeal is simply too high to be worth the extra procedures needed for the patient. *Id.*

266. *See* Interview with Randall D. Wolcott, *supra* note 14.

medical specialist, retained for specialized cases with high numbers of claims, would increase the accuracy of an ALJ decision and the fairness to the medical service provider while delivering sufficient health care to patients.[267]

VIII. CONCLUSION

The high cost of federally funded health care will reach unsustainable levels if Congress does not find a way to eliminate waste and fraud.[268] Improving the area of medical service provider reimbursement will have both positive and negative consequences on Medicare costs.[269] If ALJs and federal courts more often order Medicare to abide by ALJ reimbursement decisions, then Medicare will certainly spend more funds—but Medicare will also fairly compensate physicians for their services.[270] Medicare, however, will also avoid litigation and administrative costs if high-volume service providers do not have to re-appeal and relitigate similar or identical medical claims.[271] Courts can already close this administrative loophole by granting mandamus at the federal level.[272] The better solution is for Congress to pass a statute that creates a cause of action for unreimbursed appellants and allows for the recovery of attorneys' fees and treble damages.[273] And finally, if the Medicare administration would begin to retain independent expert witnesses at the ALJ level, it would lessen the administrative burden of subsequent appeals, increase fairness for medical service providers, and increase the quality of patient care.[274]

267. *See id.*
268. *See* Costello, *supra* note 2.
269. *See* discussion *supra* Parts V-VII.
270. *See* discussion *supra* Part V.A
271. *See* discussion *supra* Part V.A
272. *See* discussion *supra* Part V.A
273. *See* discussion *supra* Part VI.
274. *See* discussion *supra* Part VII.