Office of Medicare Hearings and Appeals (OMHA)

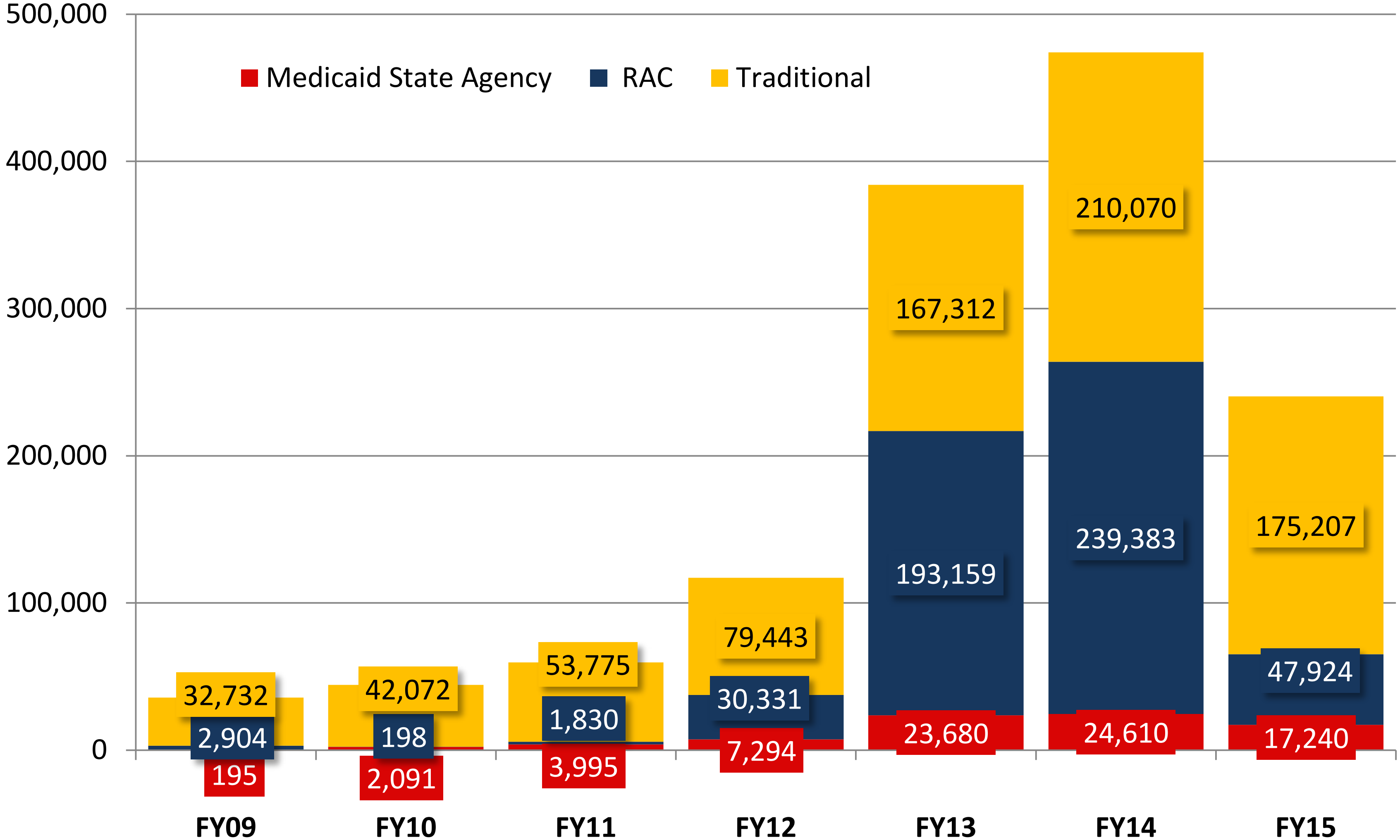
Medicare Appellant Forum – February 25, 2016

Office of Medicare Hearings and Appeals

Current Status and Initiatives

Nancy J. Griswold, Chief Administrative Law Judge
Office of Medicare Hearings and Appeals

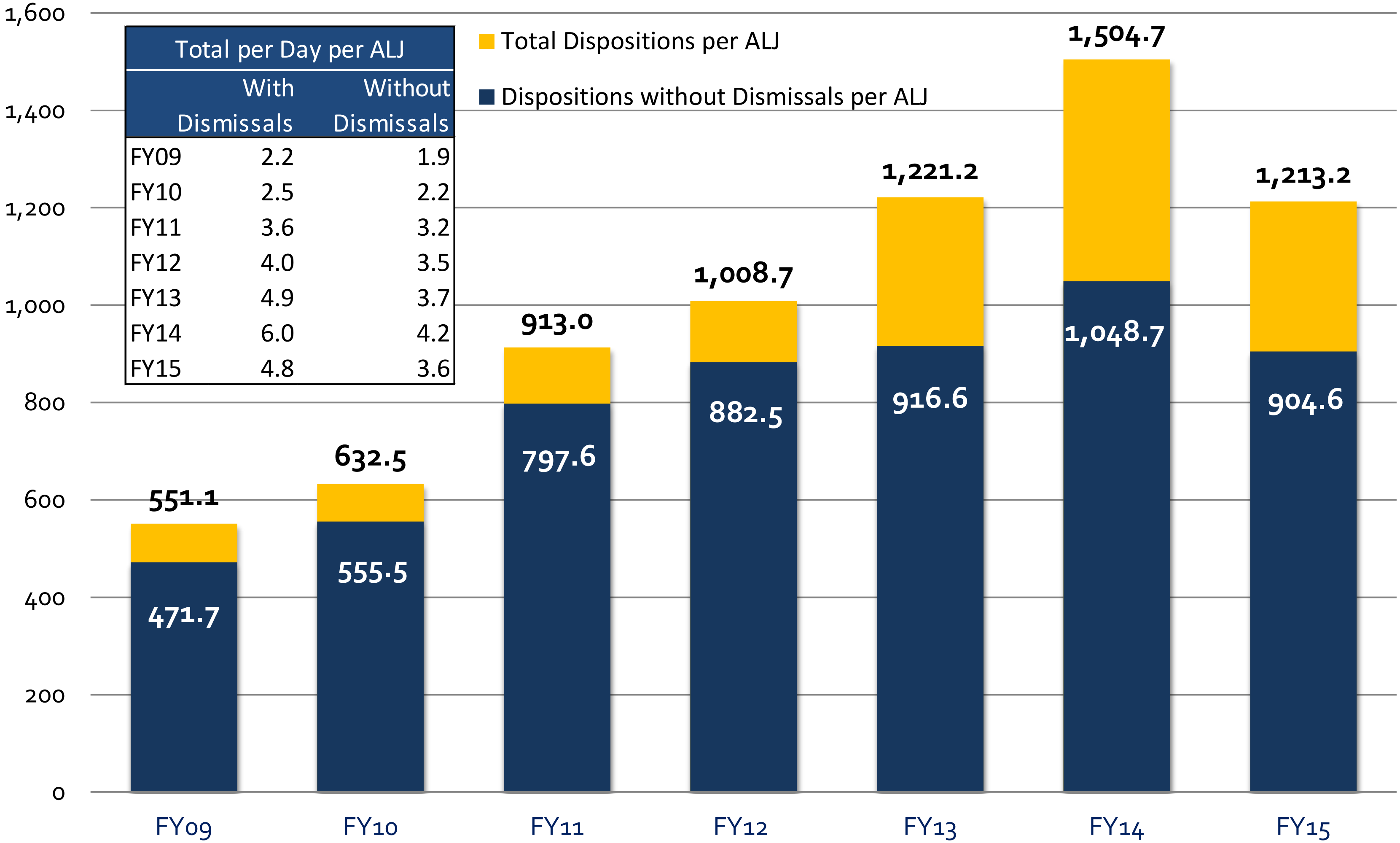
OMHA Workload – Appeals Receipts



Includes appeals with Request for Hearing Date in listed fiscal year and excludes reopened appeals.
FY14 and FY15 receipts include changes in methodology to reflect actual numbers including combined appeals.

Run Date: 1/21/2016

OMHA Workload – ALJ Productivity



Total per Day per ALJ	With Dismissals	Without Dismissals
FY09	2.2	1.9
FY10	2.5	2.2
FY11	3.6	3.2
FY12	4.0	3.5
FY13	4.9	3.7
FY14	6.0	4.2
FY15	4.8	3.6

Appeals decided in listed fiscal year and excludes remands.

Run Date: 1/21/2016

Budget

- FY 2016 Omnibus Bill provides OMHA with additional funding.
- Increase allows OMHA to:
  - Increase adjudicatory capacity
  - Add a 6th Field Office
- 2017 President's Budget request includes a legislative package to further increase adjudicatory capacity nationwide.

Adjudicatory Expansion

- With FY 2016 increase, OMHA plans to:
  - Hire 15 additional Administrative Law Judge teams (with adjudicatory support)
  - Expand Senior Judge program
  - Expand administrative initiatives
    - Settlement Conference Facilitation
    - Senior Attorney Pilot

Geographic Expansion

- Opening OMHA's 6^{th} Field Office
- Phased approach
- Temporary space with small number of teams
- Permanent location in existing federal space
- Build out and hiring over next 12-18 months
- Location to be determined

Customer Service Center

- Improving customer service to public
- Developing central contact point for appellant inquiries
- Anticipated timeframe – FY 2016
- Best source for up-to-date information still the ALJ team assigned to the case

CMS Appeals Update

Arrah Tabe-Bedward
Director
Medicare Enrollment and Appeals Group
Centers for Medicare & Medicaid Services

Agenda

- Trend Updates
- QIC Demo
- Scope of Review Guidance

Calendar Year 2015 Appeals Workload

Processed at Level 1
Parts A & B
* 3,671,524 (**2.9%)

Dismissed
(9.4%)

Favorable
(30.7%)

Partially Favorable
(6%)

Unfavorable
(53.9%)

Processed at Level 2
Parts A & B
* 1,081,712 (49.3%)

Dismissed
(6.8%)

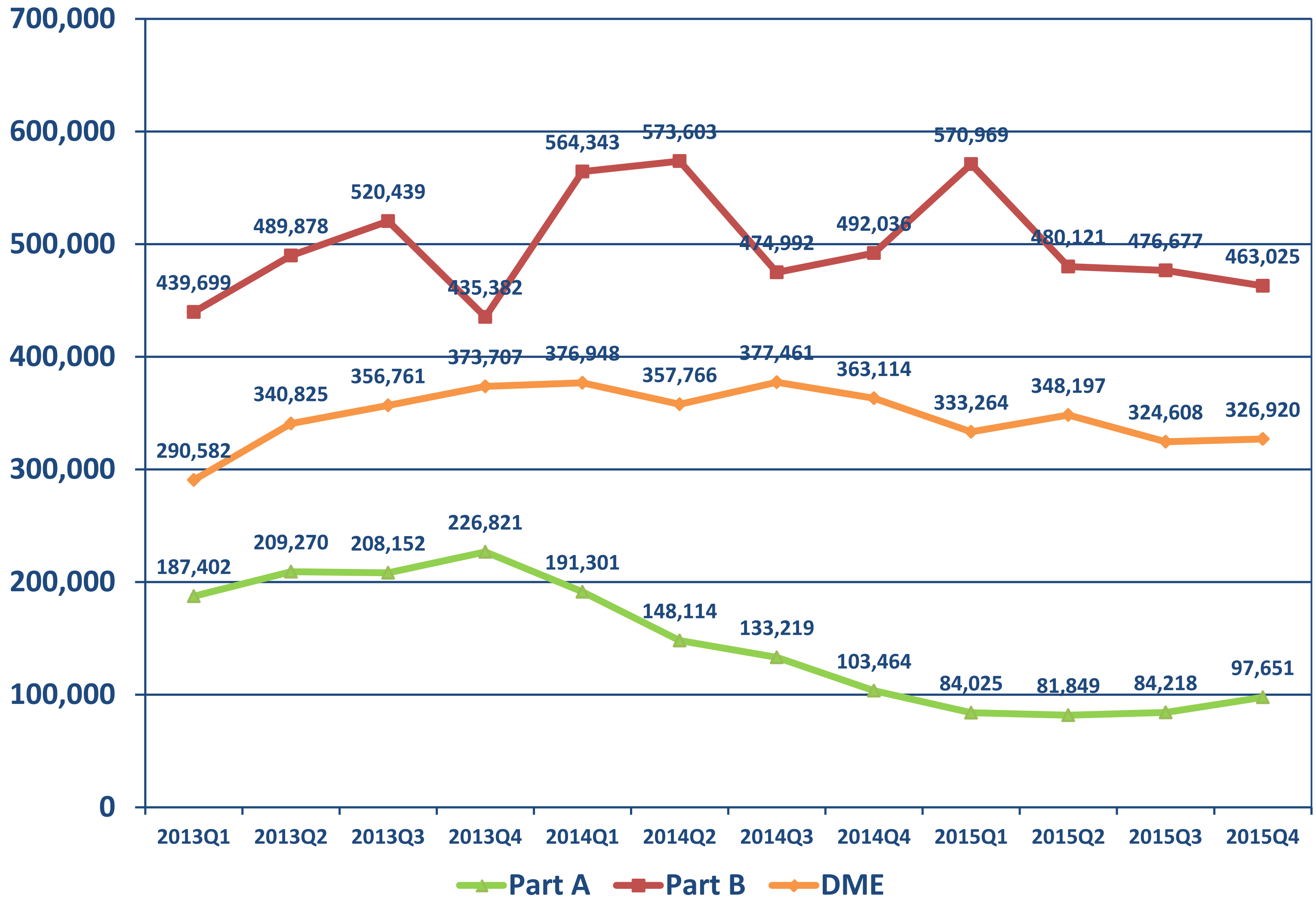
Favorable
(17.3%)

Partially Favorable
(1.6%)

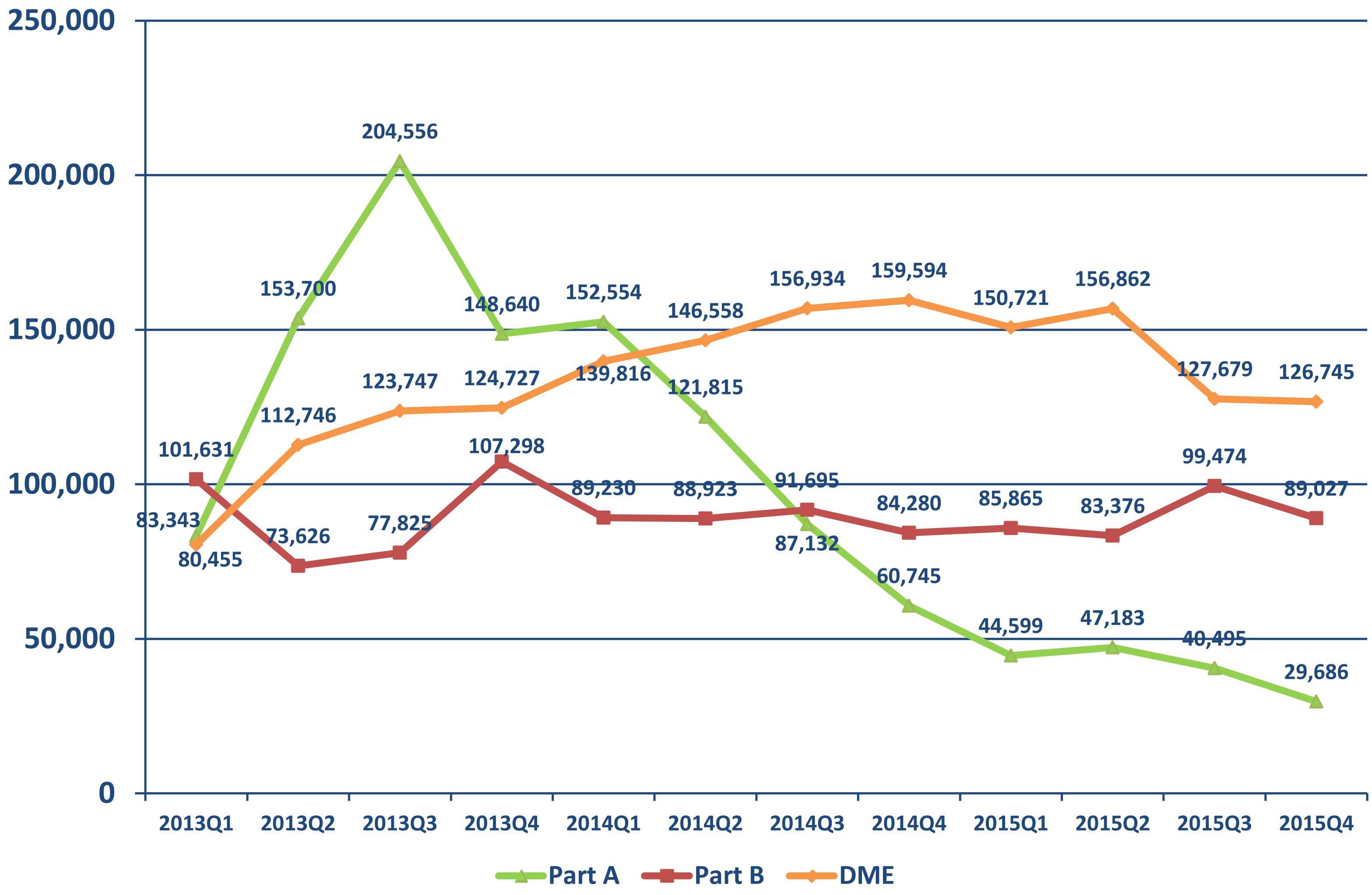
Unfavorable
(74.3%)

**Counts are in claims*
***2.9% denied claims from Initial Determination*

Medicare Administrative Contractor Appeals Workload (in claims)



Qualified Independent Contractor Appeals Workload (in claims)



QIC Demonstration - Overview

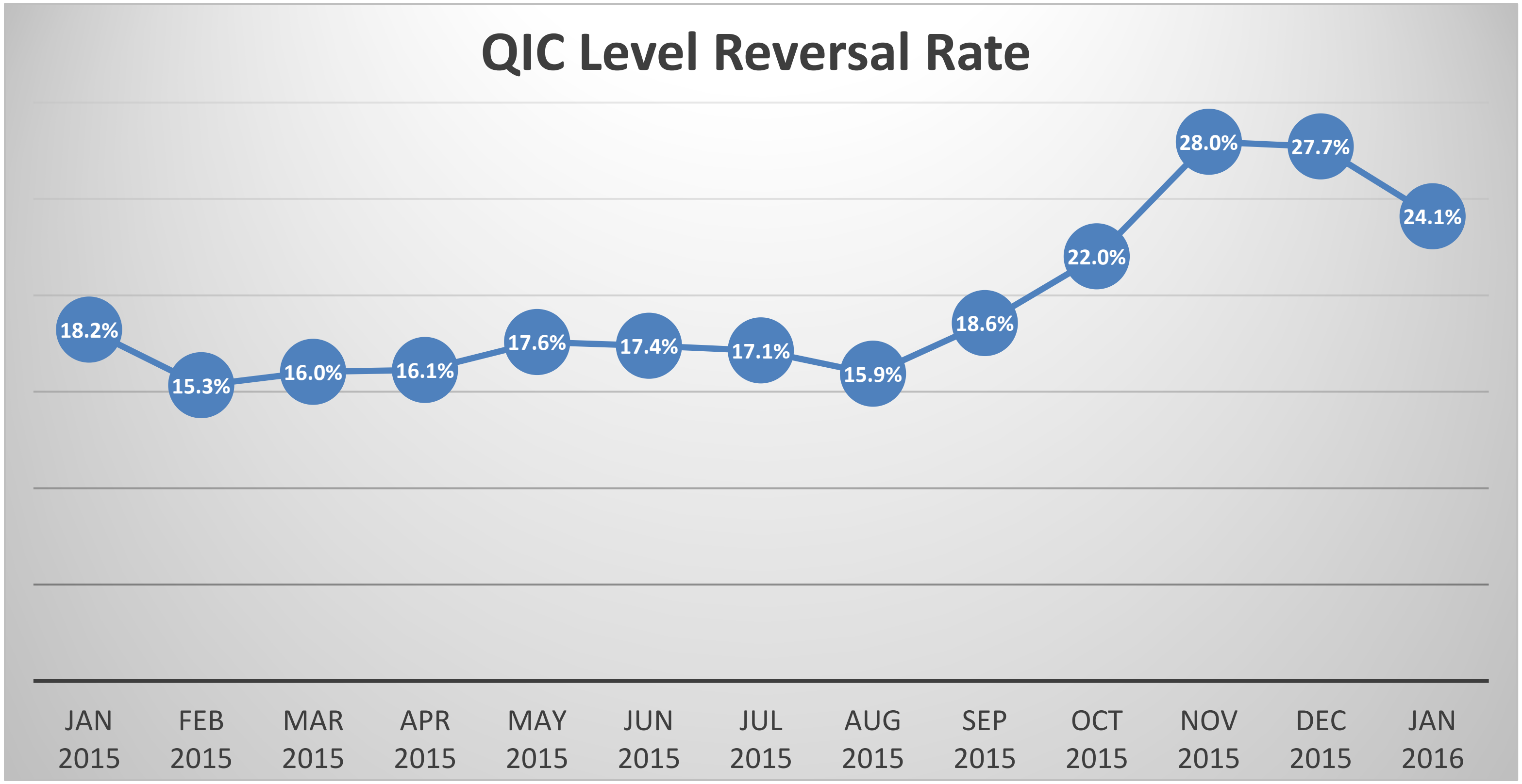
- Launched January 1, 2016
- Discussions began February 8, 2016
- Provides an opportunity for appellants and the DME QIC to engage in a discussion of appealed claims prior to the issuance of a decision
  - Prior to discussion, QIC identifies and requests missing documentation
  - During discussion, QIC clarifies Medicare policies, noting information that would yield a favorable reconsideration
- Initial focus on claims related to oxygen supplies and glucose/diabetes testing supplies from two DME Medicare Administrative Contractor (MAC) jurisdictions
- Expect an increase of proper claims submissions at the DME MACs level from suppliers participating in the discussion
- Link to demonstration website: https://www.c2cinc.com/FormalTelephoneDiscussionDemonstration.aspx

QIC Demonstration – Reopening Related Claims

- Based on information received in discussions with appellants, QIC will identify and reopen claims that have similar denial rationales that can now be resolved favorably as result of discussions process
- Prior to reopening claim, QIC will notify suppliers in writing regarding what documentation is missing from file that would yield favorable reconsideration decision as part of reopening process
- Reopening will **only** occur upon receipt of missing or otherwise relevant documentation that would yield favorable decision
- QIC will reopen claims closed but not yet appealed to ALJ level of appeal and will also work with appellants to reopen related claims currently pending at the ALJ level

Scope of Review Guidance

- Since August 2015, for Level 1 and Level 2 appeals of claims denied following a post-payment review or audit, MACs and QICs have limited their review to the reason(s) the claim was initially denied
- CMS believes this has resulted in an increase in the number of Level 2 reversals for these decisions



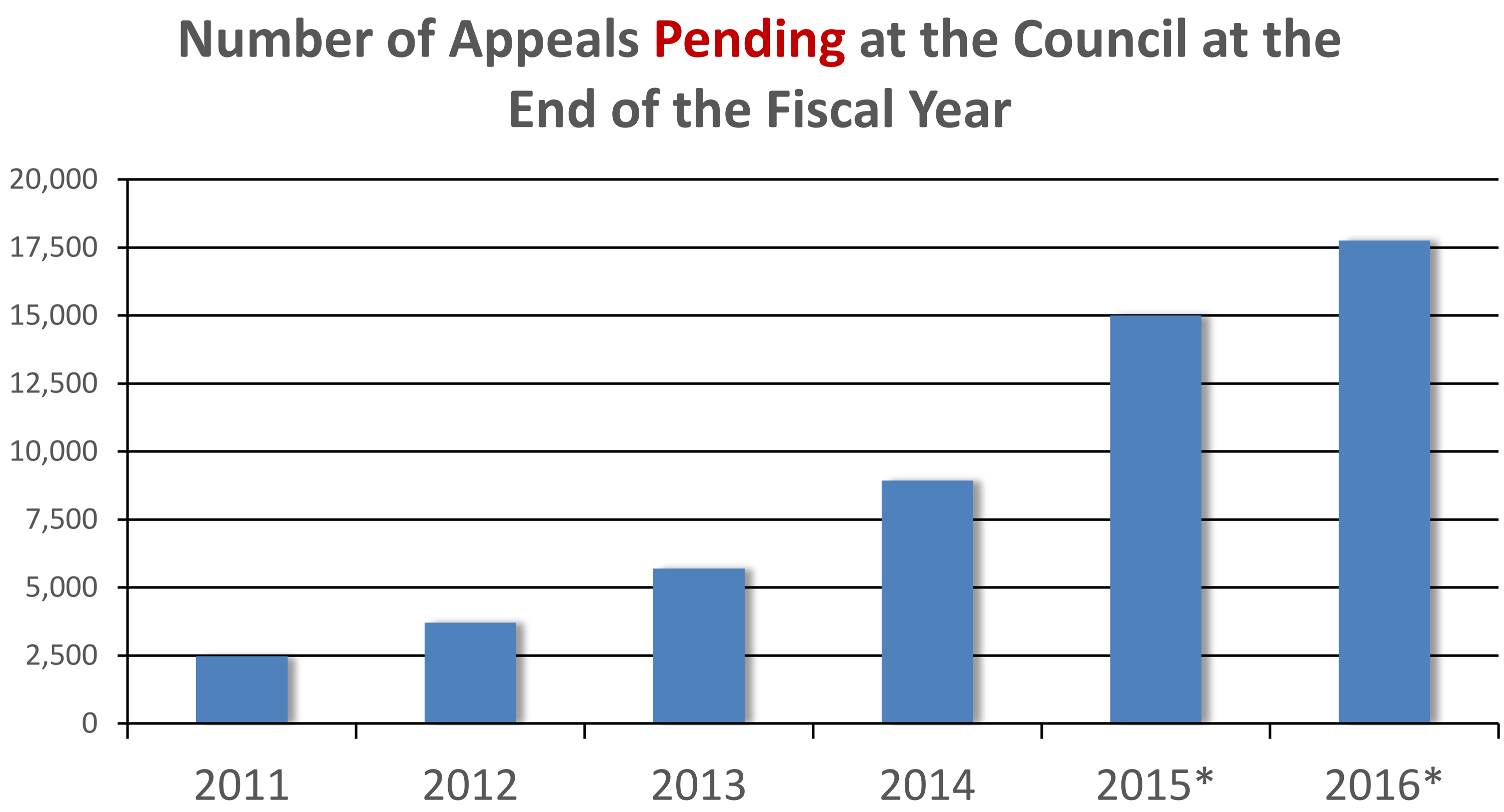
Departmental Appeals Board Update
MEDICARE APPEALS COUNCIL

Judge Constance B. Tobias
Chair, HHS Departmental Appeals Board
Department of Health and Human Services

Status of Appeals at the DAB

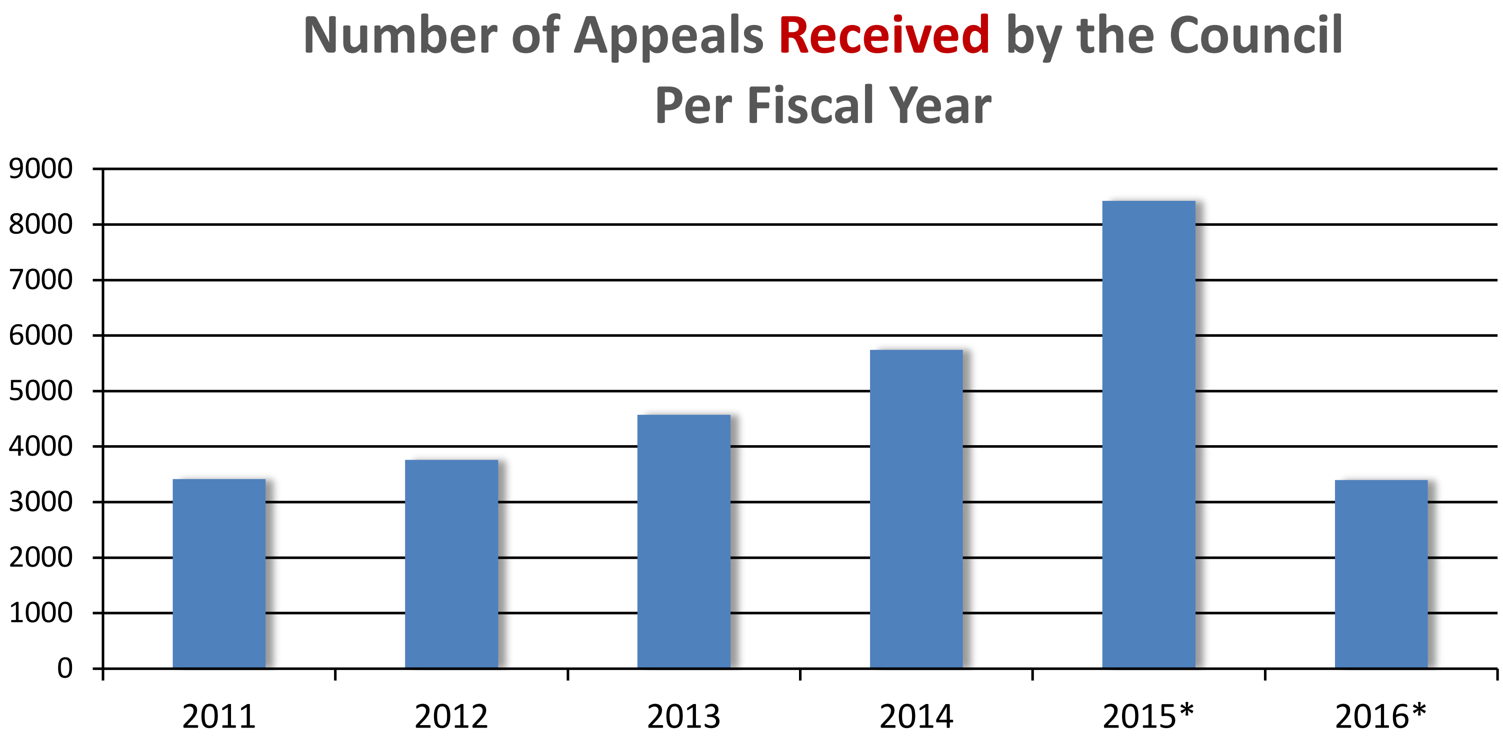
- The number of requests for Council review continues to increase.
- At the end of FY 2015, the number of pending appeals was over 15,000.
- Beneficiary appeals, including Medicare Part C and Part D pre-service claims, are being prioritized (approximately 10% of the total number of appeals).

Appeals Pending with the Council



*FY15 and FY16 year-to-date numbers are estimates as of February 3, 2016

Appeals Received by the Council



*FY15 and FY16 year-to-date numbers are estimates as of February 3, 2016

Recent Developments

- Office Move
- Personnel Changes
- Backlog Initiatives
- Other Initiatives

DAB Office Move

- The DAB moved to the Mary E. Switzer Building on December 12, 2015
- Address, telephone, and fax numbers remain the same

Personnel Changes

Appointment to the Departmental Appeals Board

- Judge Christopher S. Randolph

New Administrative Appeals Judge

- Judge Stephen M. Godek

Additional Attorney-Advisors

Backlog Initiatives

Process Management Attorney

- In October 2015, the Process Management Attorney position was created to manage the increasing number of appeals
- Focus on improving procedures and processes
- Increase efficiencies and adjudicatory capacity to achieve higher case dispositions
- Responsible for the electronic filing system and electronic records

Other Initiatives

Translation Project

- Currently working to make the DAB website and the DAB electronic-filing site available in Spanish
- Project is in testing phase
- Tentative launch date: Spring 2016

OMHA Program Updates

Jason Green

Chief Advisor

Office of Medicare Hearings and Appeals

OMHA Case Processing Manual (OCPM)

http://www.hhs.gov/omha/

OMHA Case Processing Manual (OCPM)

HHS.gov
U.S. Department of Health & Human Services

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- About OMHA
- Understanding the Appeal Process
- Coverage and Claims Appeals
- Part B Premium Appeals
- Entitlement Appeals
- OMHA Appellant Forum
- OMHA Case Processing Manual
- Forms
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- FAQs
- Data
- Glossary
- Appeal Status Lookup
- Contact Us
- Subscribe or Unsubscribe to Email List

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Fiscal Year 2017 Legislative Proposals

President's Fiscal Year 2017 Budget:

- Use recovery audit recoveries to partially fund OMHA and DAB
- Revise amount in controversy for ALJ hearing
- Establish Medicare magistrate reviews
- Expedited procedures when no fact is in dispute
- Establish a refundable filing fee
- Consolidate and sample similar claims for administrative efficiency
- New redetermination with the introduction of new evidence

QUALITY ASSURANCE PROGRAM

Karen W. Ames
Senior Executive, Program Integrity
Office of Medicare Hearings and Appeals

Purpose

- Identify trends
  - Policy interpretation
  - Case processing

- Identify best practices

- Identify topics for
  - Training of all employees
  - Policy development, clarification, or modification

Review Period and Scope

Review period:

- 6 months starting in October 2015
- Random selection of 10 cases across the agency per week

Scope:

- Part A and B appeals
- Exclude dismissals, remands, and appeals with 25 or more claims

Results of Review

Report of Findings:

- Trends
- Best practices
- Areas for improvement

Recommendations for:

- Training
- Policy development, clarification, or modification
- Process/procedure efficiencies or improvements
- Assessment measures for effectiveness of implemented recommendations

APPELLANT CLIMATE SURVEY

Purpose

- Measure Satisfaction:
  - Overall
  - Scheduling
  - Hearing format
  - Staff interaction with appellant

- Miscellaneous:
  - Demographic information
  - Clarity of case processing documents
  - Interaction with the ALJ team
  - Use of OMHA website

Purpose Cont'd

YOUR OPPORTUNITY TO:

- Have your voice heard anonymously
- Share candid and valid concerns
- Share ideas for better customer service
- Contribute to the advancement and improvement of OMHA's adjudicatory functions

Methodology

- Development
  - Coray Gurnitz Consulting, Inc. (CGC)
  - OMHA staff

- Notification Letter sent on 06/15
  - Participation is voluntary
  - Responses are confidential

Methodology - Universe

- Cases closed between 10/14 – 3/15

- Excluded:
  - Dismissed cases
  - On the record cases
  - Remanded cases
  - Cases from the same appellant Income Related Monthly Adjustment Amount Entitlement cases
  - Multi-venue cases

Methodology Cont'd

- Telephone interview:
  - ➢Schedule an appointment
  - ➢Take the survey during initial contact
- Fielding of Survey:
  - ➢6/10/15 – 9/10/15
- Respondents:
  - ➢347 respondents (64% Non-Beneficiaries; 36% Beneficiaries)

Survey Results

Overall FY15 Results:

- Satisfaction nationwide was 3.88/5.00 (5 - very satisfied)
- Strategic goal was 3.4
- Average for past 4 fiscal years is 3.98

Survey Results

- Staff courteousness and professionalism: (i.e. the full process from requesting an ALJ hearing through receipt of decision) has increased.

  - **Rating of Very Courteous**
    - **FY15: 61%**
    - FY14: 55.67%
    - FY13: 51.35%

Survey Results

Appellant Satisfaction (5 - very satisfied)

- Interaction with ALJ:
  - **FY15: 4.15**
  - FY14: 4.22
  - FY13: 4.24

- Hearing format:
  - **FY15: 4.36**
  - FY14: 4.29
  - FY13: 4.46

Recommended Next Steps

- Explore way to improve appellant experience

- Communicate hearings & appeals process and OMHA capacity improvements
  - ➢ Website changes
  - ➢ Case Processing Changes
  - ➢ Settlements/Mediation Program
  - ➢ Statistical Sampling Initiative

Appellant Public Portal

Bruce Goldin
Senior Advisor, Information Technology
Office of Medicare Hearings and Appeals

What is the Electronic Case Adjudication Processing Environment (ECAPE)?

- Commercial-Off-The-Shelf (COTS) solution that provides a configurable, dynamic workflow and case management system that supports an electronic unified OMHA business process

Release Schedule

Release 1 – Spring (June) 2016

- Case Intake
- Phase 1 of Appellant Public Portal (APP)
  - Electronic Filing Request for Hearing
  - Submission of electronic evidence
  - Appeals Status

Release 2 – Late Winter 2016-Early Spring 2017

- Appeals Adjudication
  - Assignment through Closure
  - Developed in "chunks"

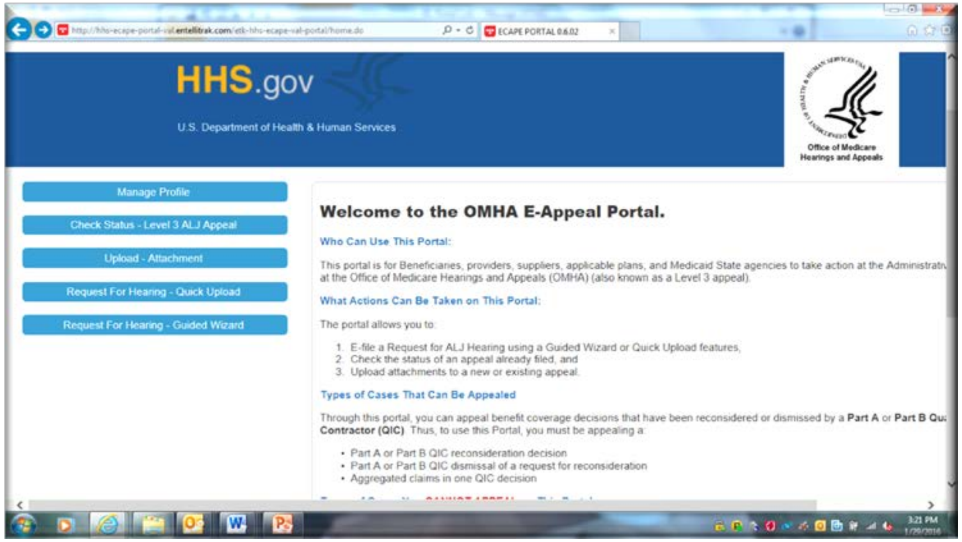
Release 3 – Spring 2017

- Enhanced Appellant Public Portal (Phase II)
  - Authenticated appellants can view files and communicate with OMHA electronically
  - Will use a two-factor authentication

Phase I of OMHA E-Appeal Portal

The portal will allow users to:

- Create and manage profiles
- Upload or create requests for hearing
- Upload evidentiary attachments
- Check status of a filed appeal



E-Appeal Functionality

System allows e-filing of Request for Hearing in 2 ways:

- Quick Upload – allows user to upload a Request for Hearing.
  - Current functionality limited to uploading one appeal at a time.
- Guided Wizard – *TurboTax*-inspired tutorial which walks user through creation of Request for Hearing

Quick Upload Screen

HHS.gov

U.S. Department of Health & Human Services

Office of Medicare Hearings and Appeals

Request For Hearing - Quick Upload

This system allows you to e-file a Request for Administrative Law Judge hearing, by simply uploading a Request for Hearing form.

To quickly uploading a Request For Hearing attachment, please enter an existing Level 2 Reconsideration Number in the box below:

- The Medicare Appeal Number (Reconsideration) (e.g. 1-############), referenced in the upper right corner of the Reconsideration Decision Letter.
  Where can I Find my Reconsideration Number on my Reconsideration Decision Letter?

If this is your first time filing an ALJ Appeal, please review the Requirements to File an ALJ appeal.

Reconsideration # R

If you are uploading a file greater then 50MB, please break up the file and upload separately in parts

Add File Browse R

Add Another File

Submit Cancel

Upload Attachments

- Allows evidence to be added to an existing appeal.
- Multiple documents can be uploaded one at a time.
- Size restricted to 50MB per document.

Attachment Upload Screen

Attachment Upload

This system allows you to upload attachments to your Medicare appeal.

To upload attachments, enter one of the following appeal numbers in the box below:

- The ALJ Appeal Number (e.g. 3-#############), referenced on the Acknowledgement Letter or Notice of Hearing from the Office of Medicare Hearings and Appeals
  Where can I find my ALJ Appeal Number on the Acknowledgement Letter?
  Where can I find my ALJ Appeal Number on my Notice of Hearing?
- The Medicare Appeal Number (Reconsideration) (e.g. 1-#############), referenced in the upper right corner of the Reconsideration decision letter
  Where can I find my Reconsideration Number on my Reconsideration Decision Letter?
- The ECAPE ID Number (e.g. E#############), referenced on the confirmation receipt of electronic Request For Hearing Submiited through the Appellant Public Portal

You may upload multiple documents, each restricted to 50MB.

Appeal Number [?]

If you are uploading a file greater then 50MB, please break up the file and upload separately in parts

Add File

Browse

Add Another File

Submit | Submit & Upload to Another Appeal | Cancel

Powered by entellitrak®

Check Status Capability

- Mirrors the functionality of AASIS.
- Phase I functionality allows the user to check the status of up to 10 appeals at a time.
  - For appeals filed in ECAPE Only
- Expanded functionality is anticipated for Phase II of development.
  - Pending appeals will be migrated into ECAPE

Implementation Plan

Portal Testing

- Usability: Members of Appellant community have tested the product and changes are being implemented based on their results.

- Beta testing: System will go live for a limited number of users who are part of an Appellant Portal Group.

Implementation Plan

Piloting

- Will pilot with a small group of Appellants and gradually increase the number of users.

Appellant Public Portal Phase II

- Will start with requirements early this spring
  - Already started collecting general feedback.

Question and Answer Period

SETTLEMENT CONFERENCE FACILITATION

Cherise Neville

Senior Attorney

Office of the Chief Judge

Teleconference Objectives

- Understand the concept of Settlement Conference Facilitation (SCF) or mediation at the Administrative Law Judge level;
- Understand the basic eligibility requirements for Phase III of the SCF Pilot; and
- Understand the SCF Phase III process

What is Settlement Conference Facilitation?

- Settlement Conference Facilitation is an alternate dispute resolution process designed to bring the appellant and the Centers for Medicare & Medicaid Services (CMS) together to discuss the potential of a mutually agreeable resolution for claims appealed to the Administrative Law Judge hearing level.

- If a resolution is reached, the settlement conference facilitator drafts a settlement document to reflect the agreement. As part of the agreement, the request(s) for an Administrative Law Judge hearing for the claims covered by the settlement will be withdrawn and dismissed.

Who is the Settlement Conference Facilitator?

Settlement conference facilitators are specially trained employees of the Office of Medicare Hearings and Appeals (OMHA), which is a component of the HHS Office of the Secretary, and is organizationally and functionally separate from CMS.

What Does the Facilitator Do?

- Uses mediation principles to assist the appellant and CMS in working toward a mutually agreeable resolution.
- Does not make official determinations on the merits of the claims at issue and does not serve as a fact finder.
- May help the appellant and CMS see the relative strengths and weaknesses of their positions.

Settlement Conference Facilitation: Phase I

SCF: Phase I

- The first phase of OMHA's SCF pilot began in June 2014.
- Limited to Part B claims appealed to OMHA in calendar year 2013.
- Phase I of the pilot successfully resolved over 2,400 unassigned Administrative Law Judge appeals.

Settlement Conference Facilitation Expansion

SCF Expansion

SCF has been expanded in two phases:

- Phase II: Expanded SCF to most provider/supplier Part B appeals where the request for ALJ hearing was filed prior to October 1, 2015. Phase II began on October 1, 2015.

- Phase III: Expands the pilot to include certain Part A appeals. Phase III opens on February 25, 2016.

SCF Phase III: Eligibility Requirements

- The appellant must be a Medicare provider or supplier (for the purposes of this pilot, “appellant” is defined as a Medicare provider or supplier that has been assigned a National Provider Identifier (NPI) number);

  - All Part A provider types are eligible to request participation in the OMHA SCF Pilot, including acute care hospitals.

  - Claims that were eligible for the CMS Part A Hospital Appeals Settlement option are **ineligible** for the pilot regardless of actual provider participation in the settlement process with CMS.

SCF Phase III: Eligibility Requirements

- A request for hearing must appeal a Medicare Part A Qualified Independent Contractor (QIC) reconsideration decision;
- The claims at issue are covered under Medicare Part A law and policy;
- The beneficiary must not have been found liable after the initial determination or participated in the QIC reconsideration;

SCF Phase III: Eligibility Requirements

- All jurisdictional requirements for a hearing before an Administrative Law Judge must be met for the request for hearing on all appealed claims;
- The request for hearing must not be scheduled for an Administrative Law Judge hearing;
- The request for hearing must have been filed by December 31, 2015;
- The amount of each individual claim must be $100,000 or less (for the purposes of an extrapolated statistical sample, the overpayment amount extrapolated from the universe of claims must be $100,000 or less):

SCF Phase III: Eligibility Requirements

- Minimum number of claims/amount in controversy;
- There cannot be an outstanding request for OMHA statistical sampling for the same claims;
- The request must include all of the appellant's pending appeals for the same item or service at issue that meet the SCF criteria.
    - Appellants may not request SCF for some, but not all of the items or services included in a single appeal.

SCF Phase III: Eligibility Requirements

- The appealed claim(s) must not involve services, drugs, or biologicals billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes (e.g., *J3490 Unclassified drugs*)

    - Equipment or items (excluding drugs or biologicals) which are billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes **<u>are eligible</u>** for SCF

SCF Phase III: Eligibility Requirements

- The appellant has not filed for bankruptcy and/or does not expect to file for bankruptcy in the future; **and**

- The appellant has received a *Settlement Conference Facilitation Preliminary Notification* stating that the appellant may request SCF for the claims identified in the SCF spreadsheet.

Requesting SCF

- Appellant submits an SCF *Expression of Interest* which requests that OMHA run a preliminary report of its pending appeals and initiate the SCF process.
- OMHA creates the preliminary report containing appellant claims which are eligible for SCF and sends to CMS.
- CMS will then have the opportunity to indicate whether it will participate in SCF for the appellant based on the preliminary report.

SCF Expansion: Requesting SCF

- Post CMS response, OMHA will complete an SCF Spreadsheet for the appellant(s) listed on the preliminary report. The SCF Spreadsheet will contain all OMHA appeals which OMHA believes are eligible for SCF.

SCF Expansion: Requesting SCF

- OMHA will send the *SCF Preliminary Notification* and *SCF Spreadsheet* to the appellant(s). The appellant will have **15 calendar days** from receipt of the *SCF Preliminary Notification* to file a complete SCF Request package.

The appellant request package must include the following items on a flash drive or a compact disc:

- *Request for SCF* form
- *SCF Agreement of Participation* form
- A complete *SCF Request Spreadsheet*: the responsibility of ensuring all claims meet SCF eligibility requirements lies with the appellant

******We will presume the appellant received the preliminary notification within 5 calendar days of the date of the notification.*

SCF Expansion: Requesting SCF

- If an appellant objects to an appealed claim on the *SCF Spreadsheet* (e.g., the claim was never appealed) or believes some claims are missing from the spreadsheet, the SCF administrative team will work with the appellant to address any issues and produce a revised *SCF Spreadsheet*, if necessary. Appellants may not request that claims be removed from the spreadsheet simply because they prefer Administrative Law Judge review of specific claims.

SCF Expansion: Requesting SCF

- If an appellant does not submit a proper SCF request package within 15 calendar days of receipt of the preliminary notification, the SCF process will close for the appeals at issue on the SCF spreadsheet.

- Once OMHA has received the appellant’s complete SCF package, OMHA will issue a confirmation notice to the appellant and CMS identifying all of the appealed claims which will be subject to the settlement conference.

SCF Expansion: Requesting SCF

- OMHA facilitates Pre-Settlement Conference Call between all parties

- OMHA facilitates Settlement Conference between all parties

SCF Expansion: Completing the SCF Process

- If an agreement is reached:
  - The OMHA facilitators will draft a settlement agreement in accordance with the instructions of all of the parties.
  - CMS and the appellant will sign the settlement agreement. The appellant must sign the agreement on the date of the settlement conference and not later.

SCF Expansion: Completing the SCF Process

- If an agreement is reached:
  - OMHA will combine the appealed claims subject to the settlement agreement into one Administrative Law Judge Appeal number for administrative efficiency and issue a single dismissal order.
  - CMS Medicare Administrative Contractors (MACs) will effectuate the settlement agreement.

SCF Expansion: Completing the SCF Process

- If the an agreement is not reached, the appealed claims will be returned to their prior place in OMHA's docket:
  - If the appeal(s) was assigned to a judge, it will return to the same judge.
  - If the appeal(s) had not been assigned to a judge, it will return to its original place in the queue for assignment (based on the date the request for hearing was received.)

Settlement Conference Facilitation Expansion: Forms

SCF Expression of Interest Form

Medicare Part A National Provider Identifier (NPI) and corresponding Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN). If claims were submitted under multiple identification numbers, list all of the identification numbers at issue.

Please **do not** handwrite NPI/PTAN or CCN numbers. If you need additional space, please attach in a separate document:

NPI	**PTAN or CCN**

Indicate whether the appealed claims pending are pre-payment denials, post-payment denials, or both:

☐ Pre-Payment ☐ Post-Payment

Has the appellant filed for bankruptcy and/or is expected to file for bankruptcy in the future? If yes, the appellant is not eligible for SCF.

SCF Request Spreadsheet

equest package. **You must review the**
f the SCF Spreadsheet via flash drive or CD is
f the information requested in this
ny way editing column headers. **NOTE: The**
egarding this spreadsheet, please contact

Appellant must complete the columns below.

Line ns ied	Payer Claim Control Number	Billed Amount Denied	Post-Payment Claim? (Enter Y for "Yes", leave blank if no)	Claim Adjustment Reason Code (CARC)	MIA/MIAO or RARC (if an	HCPCS/CPT Code	To/From Date of Service	QIC Decisio Letter Mail Date
3	0123456789874	$10,000.00		M25		A0000	1/1/2014	3/1/

Settlement Agreement Template

- Basic Agreement: The claims at issue are specified in the Spreadsheet and pages Page X– Page Y of this agreement. CMS agrees to calculate payment based upon a percentage term of **[agreed percentage number].**

- Percentage (%) terms in this agreement: For pre-payment denials at issue in this agreement (including down-coding), the percentage agreed to by CMS is a percentage of the Medicare approved amount less the applicable deductible and/or co-insurance (that is, the percentage is applied only after the deductible and/or co-insurance has been subtracted from the Medicare approved amount), if any. Where down-coding is involved, the amount already paid by Medicare (constructively or otherwise) is subtracted from the preceding calculated amount. For post-payment denials at issue in this agreement, the percentage agreed to by CMS is the percentage by which CMS will reduce the overpayment(s) at issue.

Question and Answer Period
Settlement Conference Facilitation (SCF) Only