Appellant Forum – Update from OMHA

June 25, 2015

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

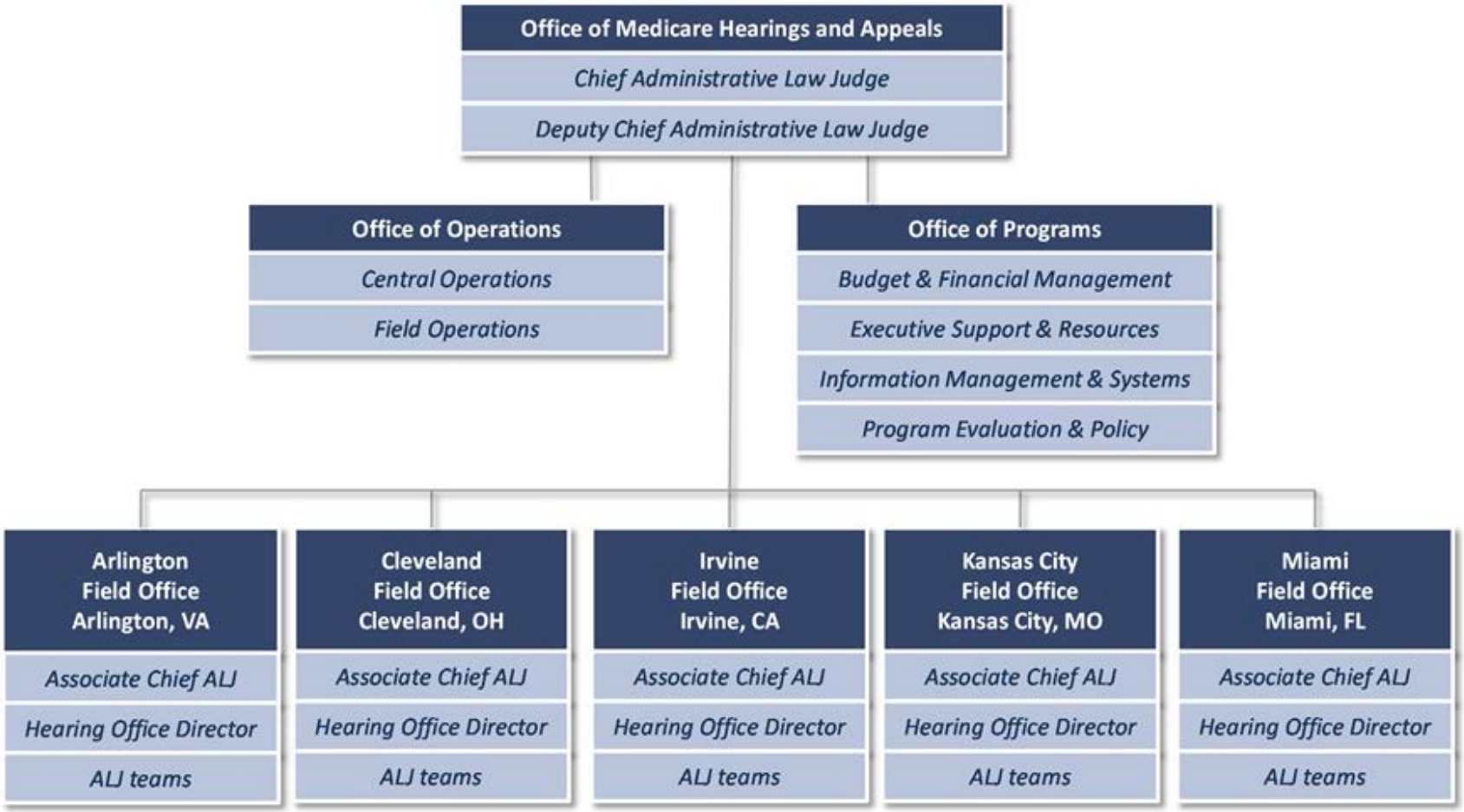
http://www.hhs.gov/omha
Medicare.Appeals@hhs.gov

Background

- The Office of Medicare Hearings and Appeals (OMHA) operates within the Office of the Secretary of the U.S. Department of Health and Human Services and administers the nationwide ALJ hearings program for Medicare benefit and claim appeals (generally the third of four levels of administrative appeal).

- OMHA is organizationally and functionally separate from the Centers for Medicare and Medicaid Services (CMS).

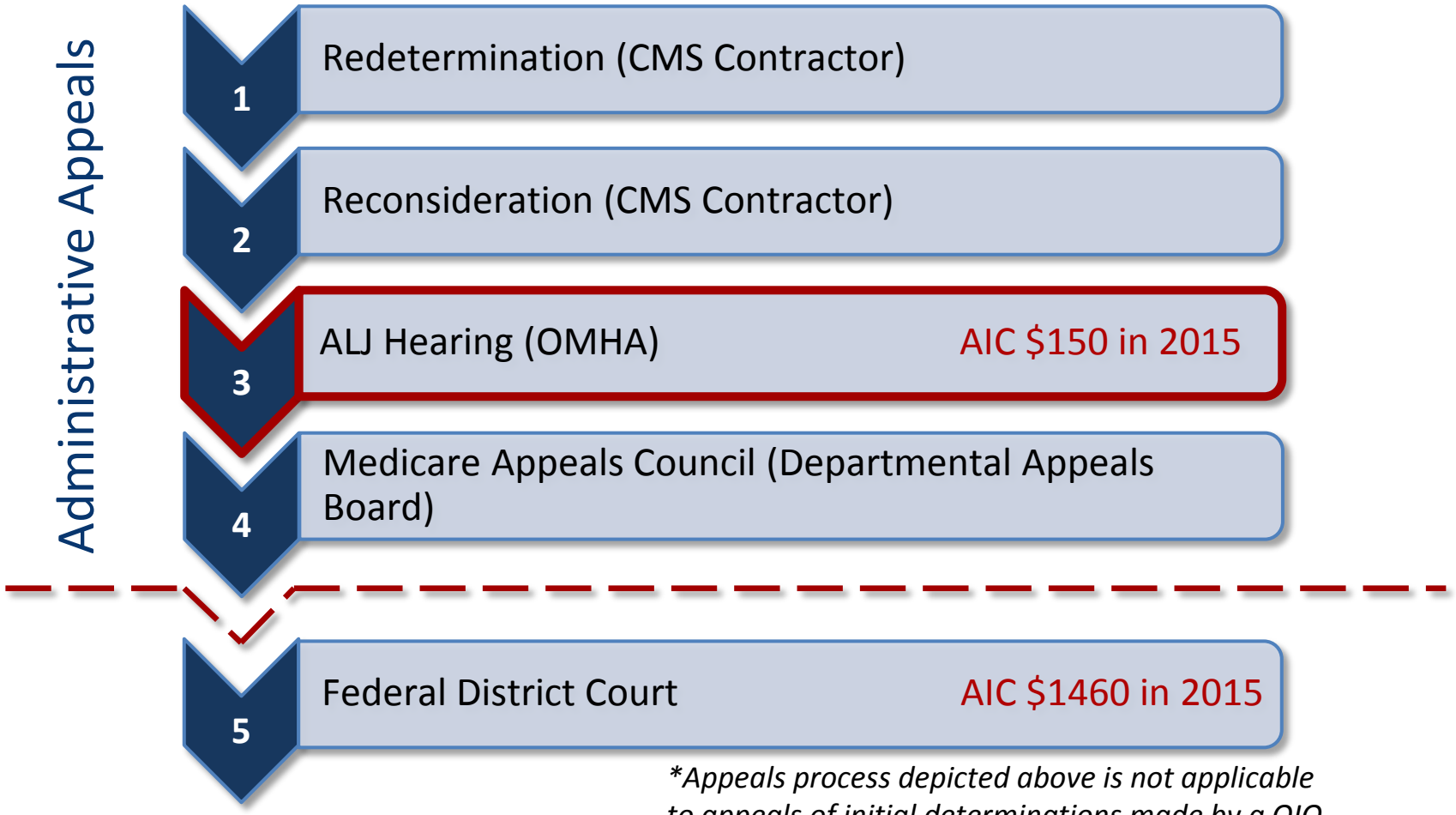
- *Our Mission*: OMHA is a responsive forum for fair, credible, and timely decision-making through an accomplished, innovative, and resilient workforce. Each employee makes a difference by contributing to shaping American health care.


Office of Medicare Hearings and Appeals
Chief Administrative Law Judge
Deputy Chief Administrative Law Judge
Office of Operations
Central Operations
Field Operations
Office of Programs
Budget & Financial Management
Executive Support & Resources
Information Management & Systems
Program Evaluation & Policy
Arlington Field Office Arlington, VA
Associate Chief ALJ
Hearing Office Director
ALJ teams
Cleveland Field Office Cleveland, OH
Associate Chief ALJ
Hearing Office Director
ALJ teams
Irvine Field Office Irvine, CA
Associate Chief ALJ
Hearing Office Director
ALJ teams
Kansas City Field Office Kansas City, MO
Associate Chief ALJ
Hearing Office Director
ALJ teams
Miami Field Office Miami, FL
Associate Chief ALJ
Hearing Office Director
ALJ teams

Jurisdiction

- Part A and B Claim Appeals
  - Pre- and post-payment denials
  - Medicare Secondary Payer (MSP) recoveries
- Part C Medicare Advantage Organization determinations
- Part D prescription drug coverage determinations
- Provider service termination and hospital discharge appeals (QIO)
- Medicare eligibility & entitlement determinations made by SSA
- Part B and D Income-Related Adjustment Amount (IRMAA) determinations made by SSA

Jurisdiction (Part A and B Claim Appeals*)



**Appeals process depicted above is not applicable to appeals of initial determinations made by a QIO.*

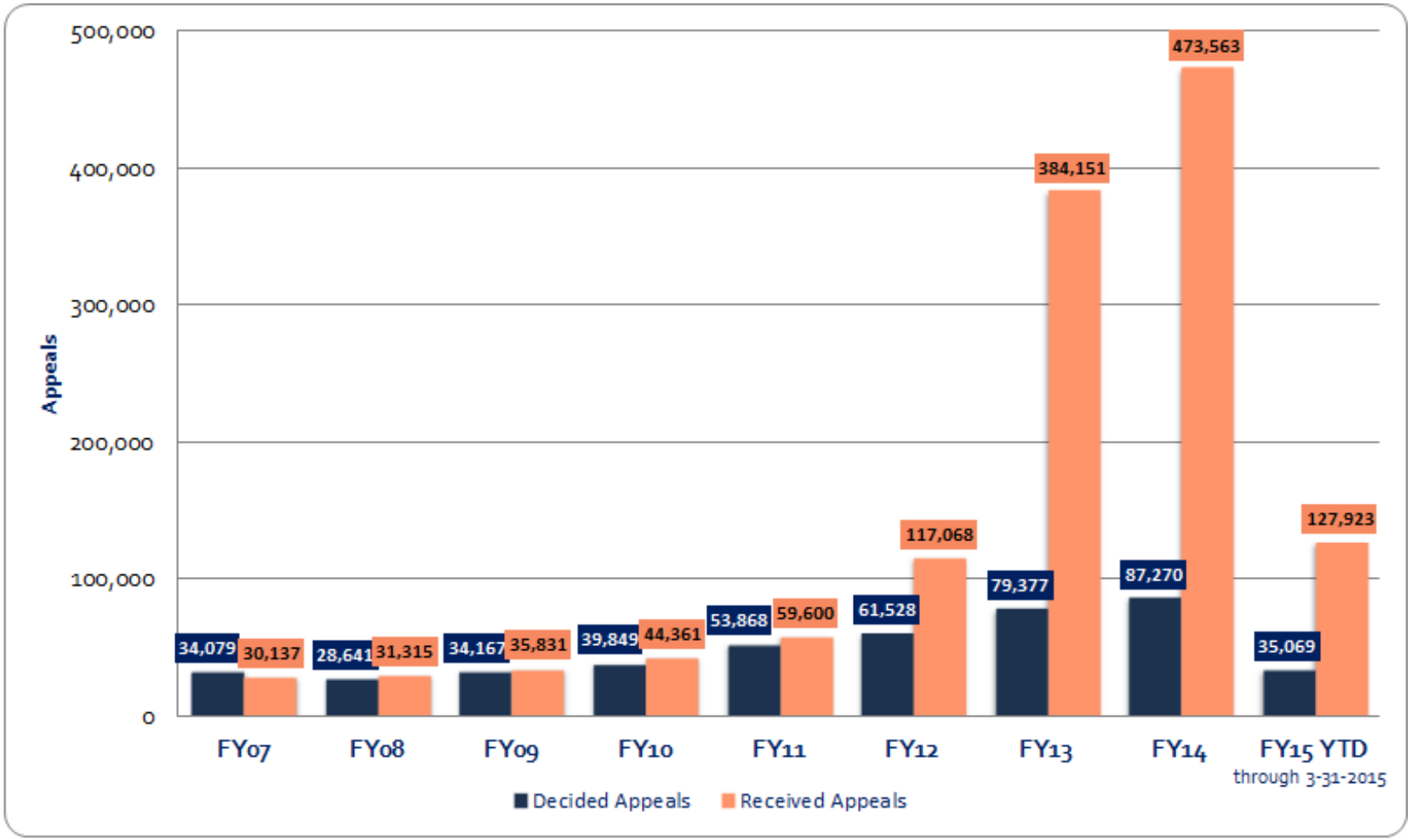
Workload Overview

- FY 2013 appeal receipts exceeded 384,000, over 3 times the FY 2012 receipts level (117,000).
- FY 2014 appeal receipts were approximately 473,000.
- FY 2015 through 3/31/15 appeal receipts are approximately 128,000.
- In FY 2014, ALJs decided or dismissed an average of 1,505 appeals.
- In FY 2015 through 3/31/15, ALJs decided or dismissed an average of 540 appeals per team.
- Despite higher-than-ever ALJ productivity, total *sustainable* annual adjudicatory capacity is still only approximately 75,000 appeals
- Average processing time for appeals decided in FY 2015 thus far is 588.9 days.
- Beneficiary appeals (approximately 1% of workload) receive priority

Reasons for Increase

- Significant, sustained growth in appeals workload compared to moderate budget increases
- Increased workload due to:
  - Cumulative effect of post-payment audit programs:
    - Medicare Administrative Contractors (MACs)
    - Recovery Auditors (RAs)
    - Zone Program Integrity Contractors (ZPICs)
    - Supplemental Medical Review Contractor (SMRC)
  - More active Medicaid State Agencies (MSAs)
  - Increase in traditional workload
  - Larger beneficiary population

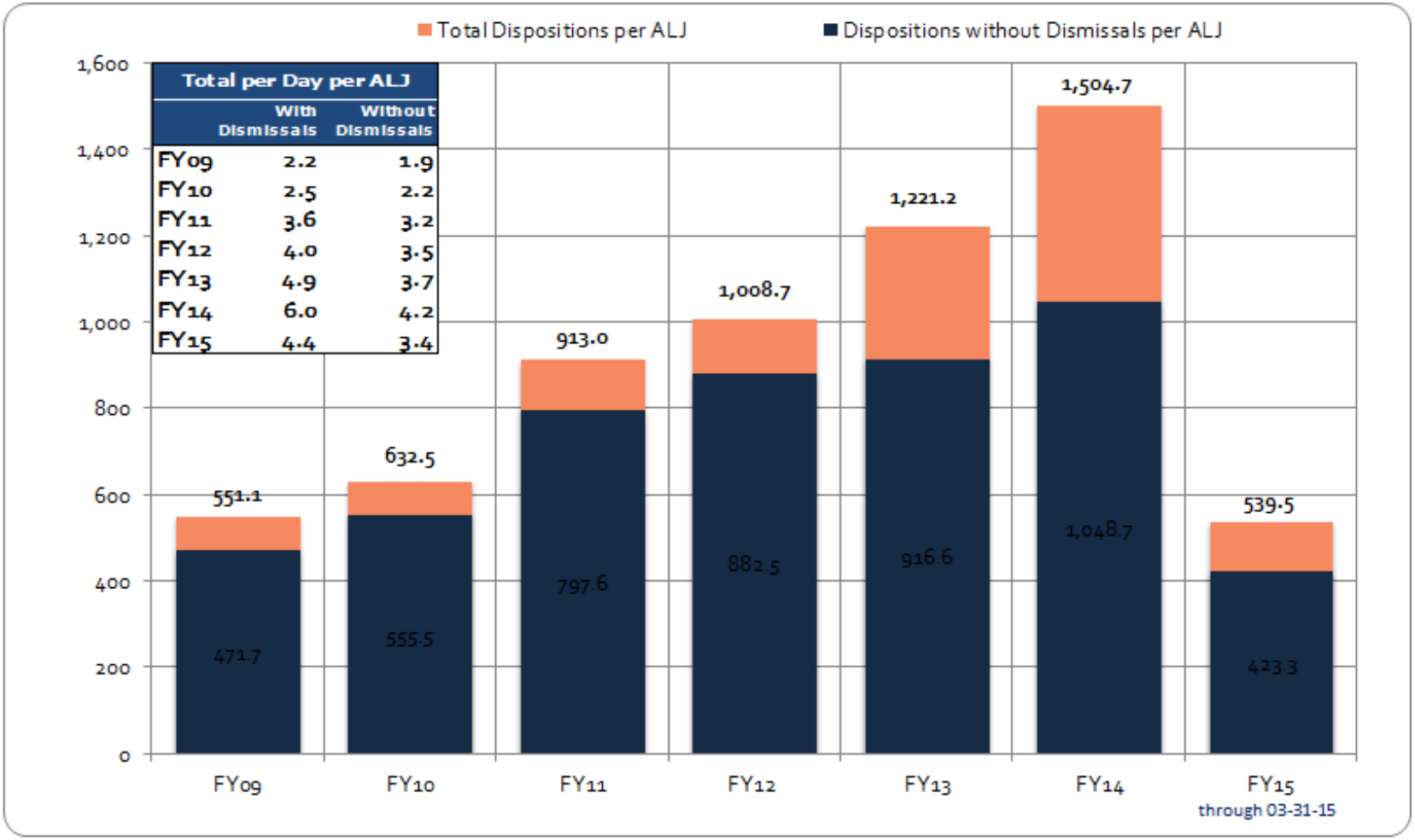
Receipts vs. Decisions Issued



Received appeals represents cases with Request for Hearing Date in listed fiscal year and excludes reopened appeals.
Fiscal Years 2014 and 2015 reflect changes in methodology to include combined appeals.
Decided appeals represents cases decided in listed fiscal year and excludes remands.

Run Date: May 1, 2015

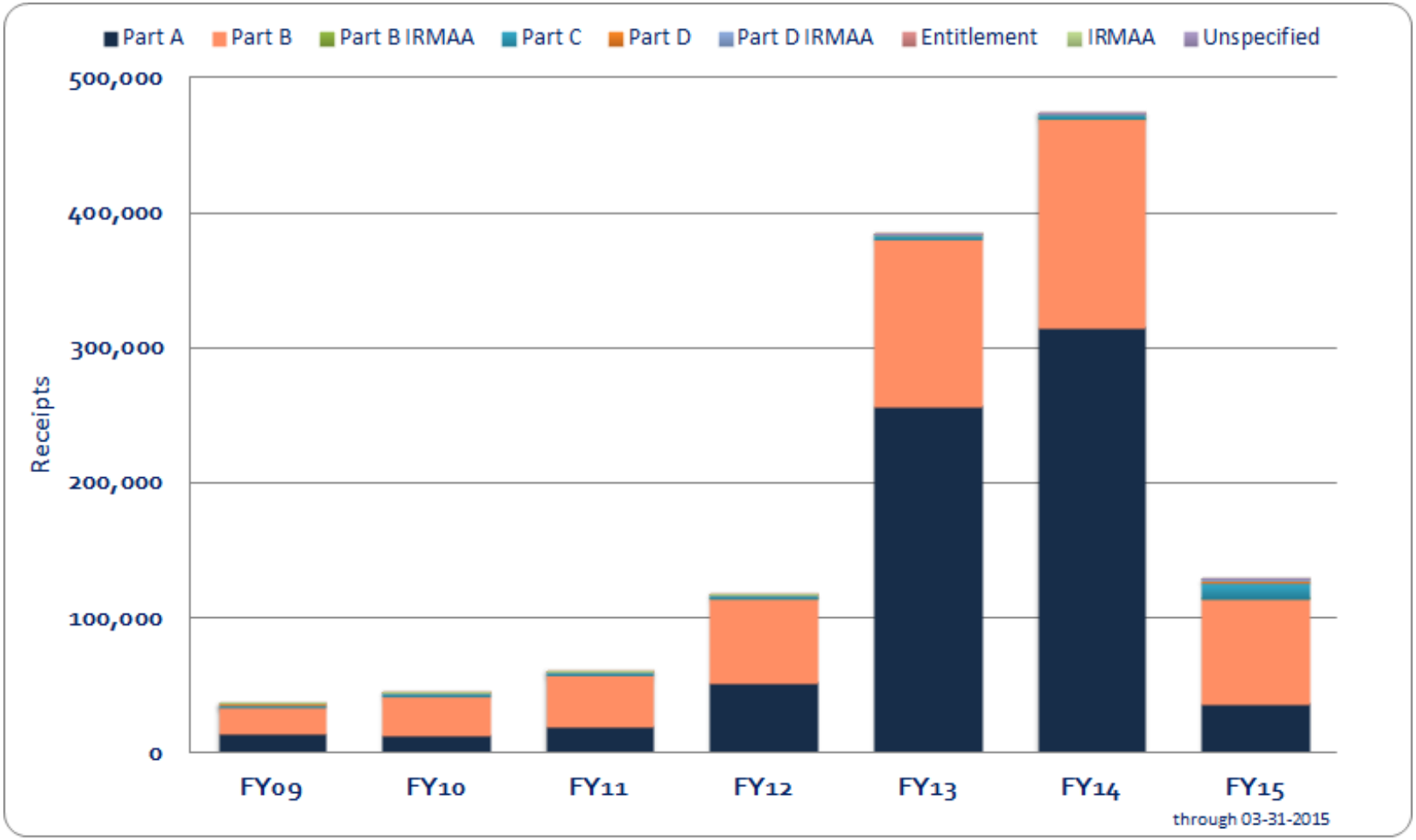
ALJ Productivity



Appeals decided in listed fiscal year and excludes remands.

Run Date: May 1, 2015

Receipts (by Medicare Type)



Received appeals represents cases with Request for Hearing Date in listed fiscal year and excludes reopened appeals.
Fiscal Years 2014 and 2015 reflect changes in methodology to include combined appeals.

Run Date: May 1, 2015

Beneficiary Appeal Prioritization

- July 2013, OMHA established an appeal prioritization policy to ensure responsiveness to beneficiaries :
  - Part D expedited appeals
  - Other beneficiary appeals
  - All other appeals
- "Beneficiary Mail Stop" is for beneficiaries or their representatives to self-identify
- FY 2014 = 5,276 beneficiary appeals
  - Average wait time for disposition = 136.2 days
- FY 2015 = 3,722 beneficiary appeals (year to date)
  - Average wait time for disposition = 69.8 days

Budget vs. Claims Workload

FY	Budget
2006	$59,359,000
2007	$59,727,000
2008	$63,864,000
2009	$64,604,000
2010	$71,147,000
2011	$71,005,000
2012	$72,011,000
2013	$69,444,000
2014	$82,381,000
2015	$87,381,000

39% Increase from 2006 to 2014

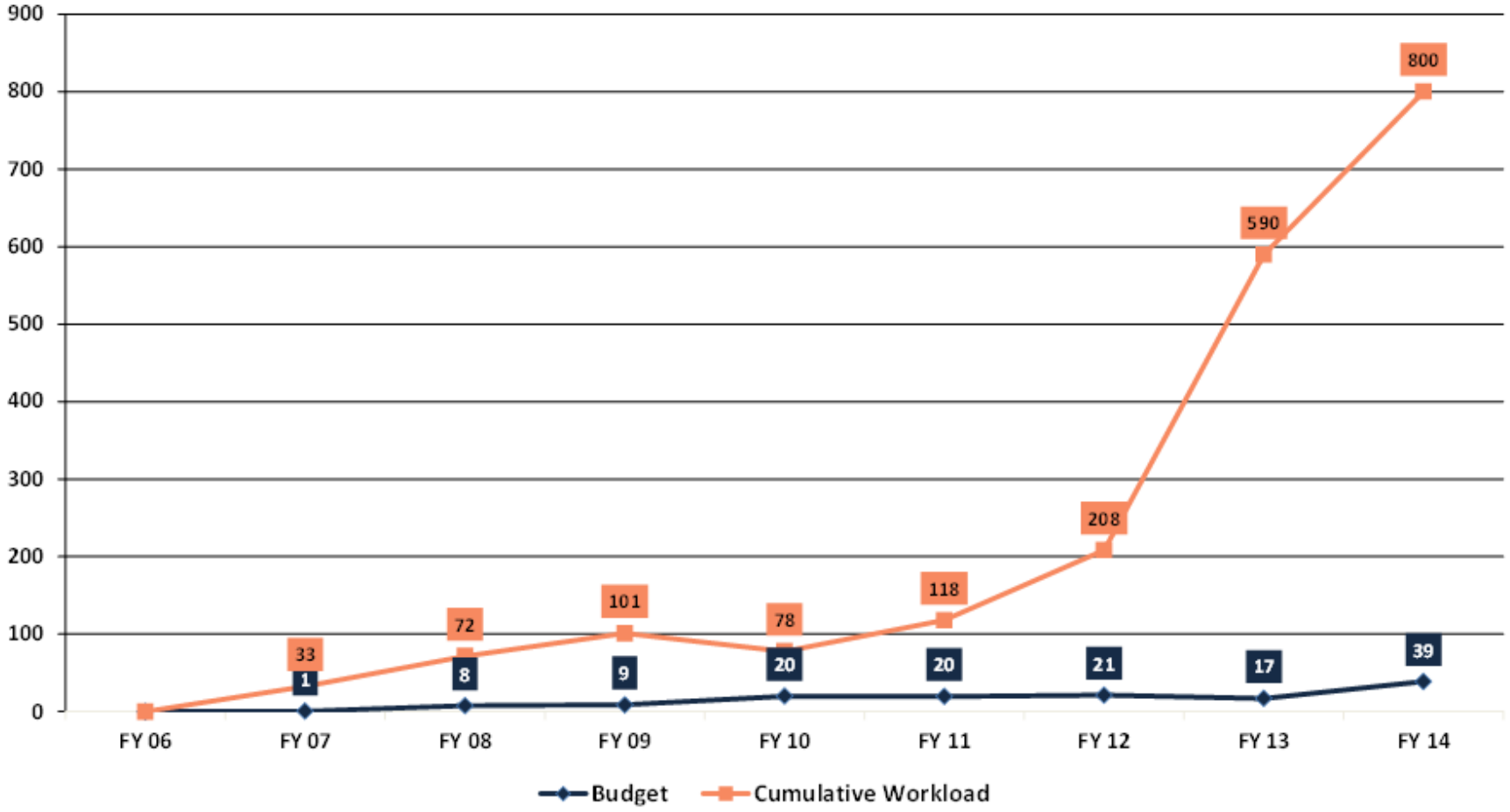
FY	Claims
2006	95,000
2007	126,000
2008	163,000
2009	191,000
2010	169,000
2011	207,000
2012	293,000
2013	655,000
2014	855,000
2015	650,000

projected

800% Increase from 2006 to 2014

Budget vs. Claims Workload

Percent Increase Over FY 06

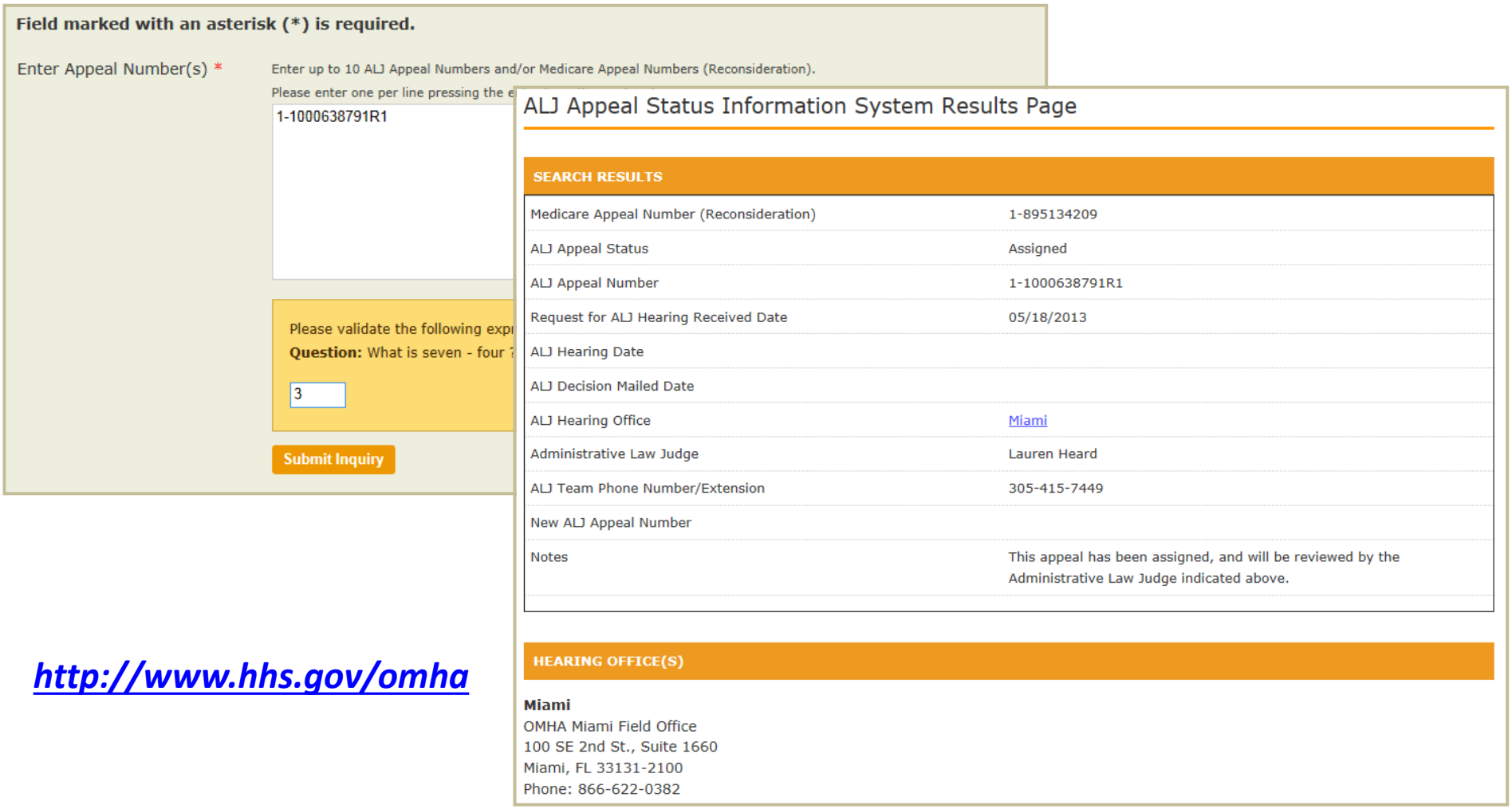


IT Initiatives

- ALJ Appeals Status Information System (AASIS)
- Electronic Case Adjudication and Processing Environment (ECAPE)
- Listserv
- OMHA Website
- Scanning Initiative

ALJ Appeal Status Information System (AASIS)

- AASIS went live December 2014 and is accessible through OMHA website: http://www.hhs.gov/omha
- Appellants can enter 1 to 10 appeal numbers at a time
- System returns information on docketed appeals, including:
  - Appeal status
  - Date request for hearing was received
  - Field office/ALJ assignment and ALJ team phone number (if assigned)
  - Date decision letter was mailed (if applicable)



http://www.hhs.gov/omha

ECAPE

- Scan all unassigned Requests for Hearing and associated documents
  - Separate contract, already underway
- Release I
  - Case Intake
  - Appellant Public Portal (Phase I)
    - Electronic filing of Request for Hearing
    - Submission of electronic evidence
- Release II
  - Appeal adjudication from ALJ assignment through closure
- Release III
  - Enhanced Appellant Public Portal (Phase II)
    - Authenticated parties can view files electronically
    - Communication to and from OMHA

Listserv

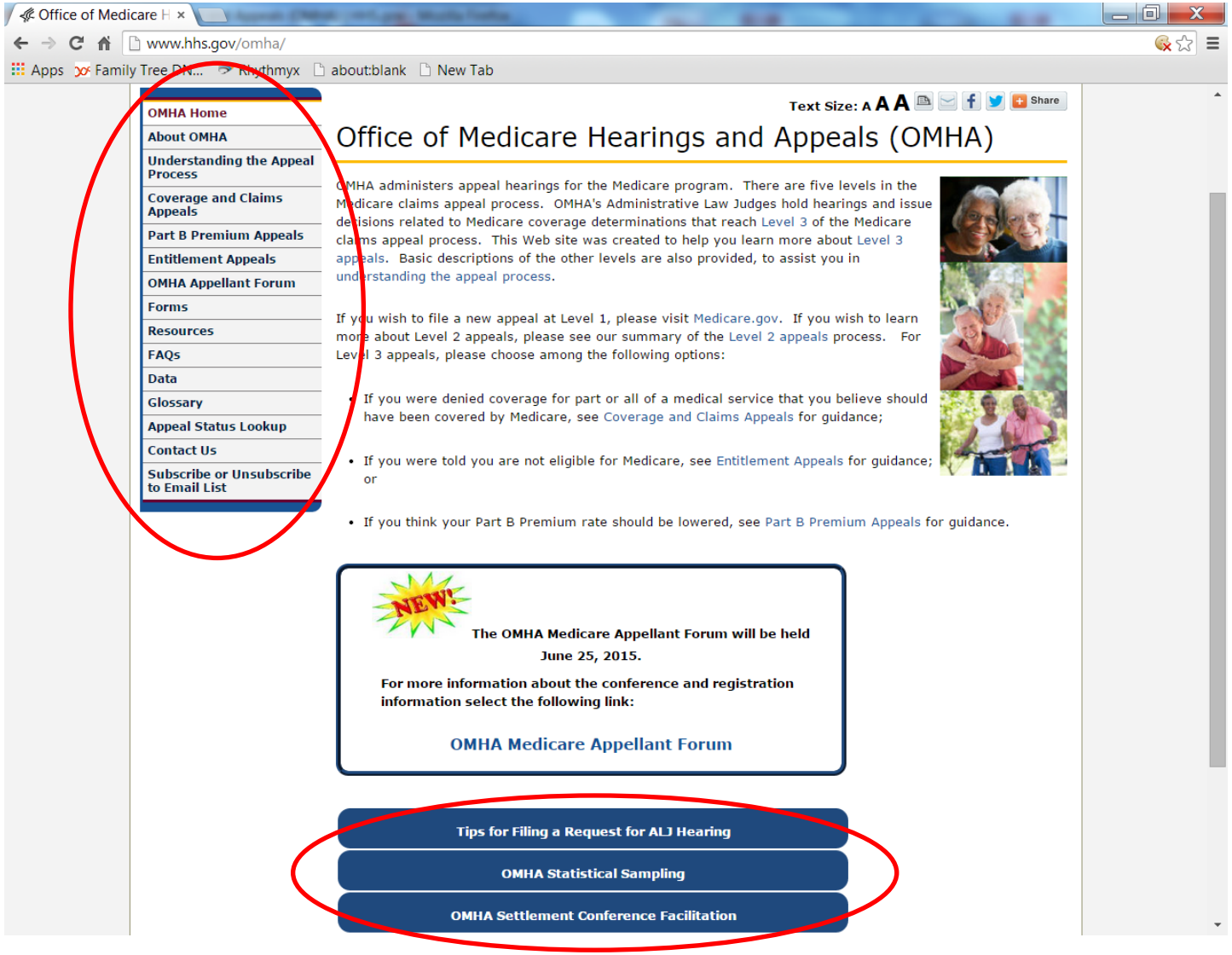
- OMHA established a listserv in February 2015 to provide updates to our appellants regarding:
  - the appeals process,
  - special initiatives,
  - pilot processes,
  - appellant forums
  - OMHA website updates,
  - and other information pertinent to their appeals.

The instructions/links to subscribe to OMHA's listserv are available on http://www.hhs.gov/omha/

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

- The place to go for..
  - AASIS
  - the Listserv
  - tips/hints and FAQs
  - information on the appeals process
  - project status information
  - workload data
  - contact information
  - OMHA initiatives
  - forms

OMHA Website



Scanning Initiative

- Contract awarded in December 2014
- Scan all unassigned Requests for Hearing and associated documents received in Central Operations
  - Transition to ECAPE
  - Enhanced case management capabilities
- Production began in June 2015
  - Scanning of documents received during third quarter of FY14 (April 2014)

Non-IT Program Initiatives

Settlement Conference Facilitation

Statistical Sampling Initiative

Senior Attorney On the Record Pilot

Settlement Conference Facilitation

- Pilot: Unassigned Part B provider/supplier appeals filed in 2013.
- OMHA acts as the conference facilitator – CMS and the appellant discuss potential resolution through settlement.
  - If the parties reach agreement, a settlement agreement is signed and OMHA dismisses the appeals.
  - If no agreement is reached, appeals return to prior status and place in queue.
- Distinct from CMS Part A hospital administrative agreement option (requests were due to CMS 10/31/14).
- Expansion:
  - Include more pending appeals
  - Include option for Medicaid State Agencies

See OMHA website for more detailed requirements, instructions, and a description of the process. Email questions to OMHA.SCF@hhs.gov

Statistical Sampling Pilot

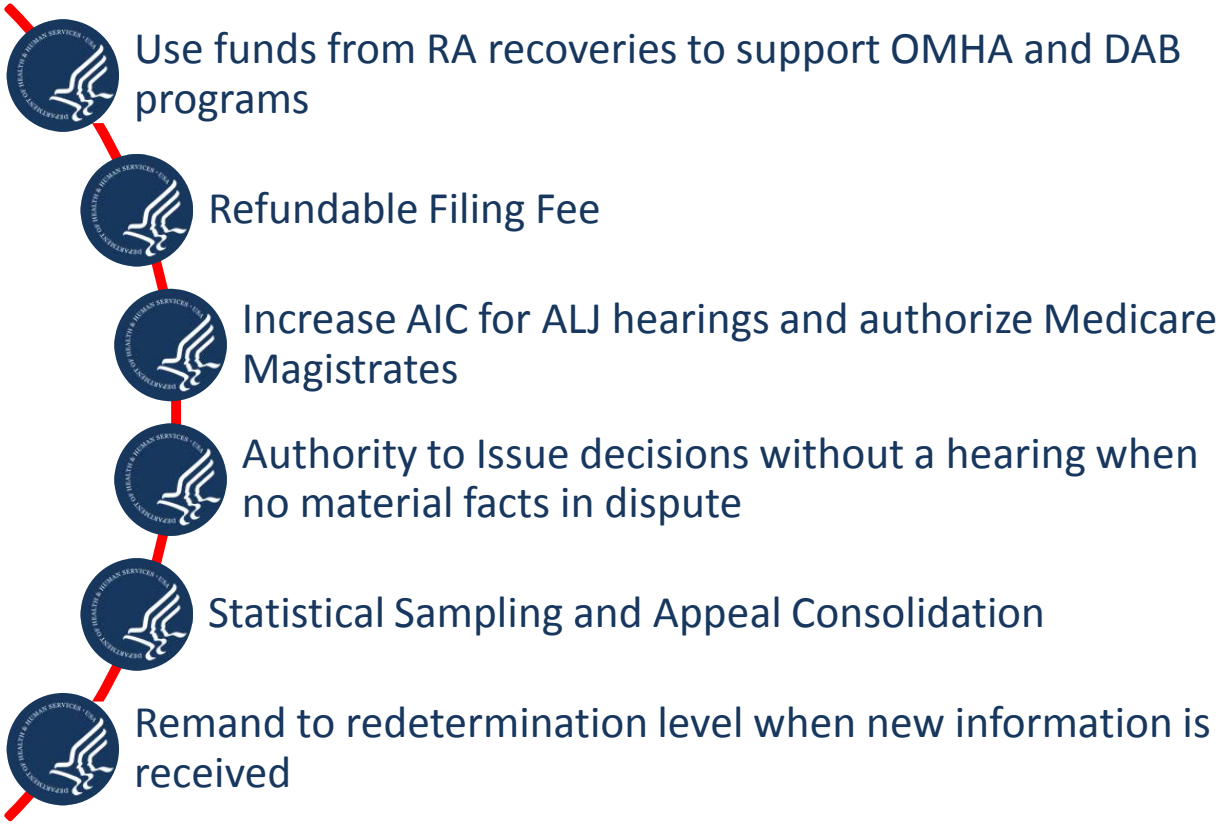
- Appellants may request or be invited to participate if they have a sufficient number of pending Part A/B claims that meet pilot criteria (currently 250 claims from quarter of appeals being assigned)
- OMHA independent statistician used.
  - Sample methodology in accordance with Medicare Program Integrity Manual (CMS Pub. 100-08, Ch. 8)
  - Statistician select sample
  - ALJ makes decision on sample units
  - Statistician extrapolates results to universe of claims
  - CMS contractors apply payment amounts and effectuates
- Expansion:
  - Include more pending appeals
  - Revise process to potentially include multiple adjudicators

See OMHA website for more detailed requirements, instructions, and a description of the process. Email questions to OMHA.stat.sampling@hhs.gov

Senior Attorney Emphasis Hearing Waivers

- Pilot concept: Use OMHA senior attorneys to assist in processing appeals in which oral hearing was waived by the appellant.
- Concept parameters:
  - Oral hearing waived by appellant.
  - No non-appellant parties are liable for the items or services.
  - Decision is based on evidence in the record.
  - Outcome can be favorable or unfavorable.
- Scope of pilot will begin with existing waivers of hearing, beginning with appeals currently being assigned.

Proposals in President's Budget



- Use funds from RA recoveries to support OMHA and DAB programs
- Refundable Filing Fee
- Increase AIC for ALJ hearings and authorize Medicare Magistrates
- Authority to Issue decisions without a hearing when no material facts in dispute
- Statistical Sampling and Appeal Consolidation
- Remand to redetermination level when new information is received

Decisional Statistics

Appeals	FY12	FY13	FY14	FY15 (Data through March 2015)
Fully Favorable	53.2%	44.3%	36.7%	38.4%
Partially Favorable	6.4%	5.2%	2.8%	3.7%
Unfavorable	27.9%	25.5%	30.1%	35.9%
Dismissed	12.5%	25.0%	30.4%	22.0%

Claims	FY12	FY13	FY14	FY15 (Data through March 2015)
Fully Favorable	33.8%	35.1%	28.4%	33.2%
Partially Favorable	16.4%	11.5%	11.5%	8.4%
Unfavorable	34.1%	28.6%	31.5%	33.6%
Dismissed	15.7%	24.7%	28.7%	24.8%

Includes appeals/claims decided in listed fiscal year, excluding remands.
Does not reflect any actions taken by the Medicare Appeals Council

Run Date: May 1, 2015

Practice Tips

- Evaluate strength of case before filing. Any legal bars to Medicare coverage?

- ALJs are bound by, and may not deviate from the terms of:
  - Statutes (Social Security Act)
  - Regulations (C.F.R.)
  - CMS Rulings
  - National Coverage Determinations (NCDs)

- ALJs are not bound by, but must give *substantial deference* to:
  - CMS manuals and interpretive guidance
  - CMS contractor Local Coverage Determinations (LCDs)

- *Note*: Prior decisions from the Medicare Appeals Council or another ALJ have no precedential value.

Practice Tips

- Be familiar with and cite to applicable Medicare law and policy
- Consider submitting a written pre-hearing brief that:
  - Outlines argument for coverage
  - Clearly applies relevant coverage criteria to the facts
  - Points to specific documentation
  - Provides a timeline
- Submit all required documentation early on
  - Documentation identified as missing in CMS contractor decision letters
  - Good cause required for evidence submitted for the first time by a provider or supplier at the ALJ level of hearing or above. 42 C.F.R. § 1018(c)

Practice Tips

- If a non-binding authority supports non-coverage, explain why you believe the ALJ should depart from the policy.
  - An ALJ may find that claim-specific facts warrant a limited, interpretive exception to an LCD or an interpretive manual
  - An OMHA ALJ may *not* find that an LCD or a provision of an LCD is invalid.
    - LCD review is conducted by ALJs of the Civil Remedies Division of the Departmental Appeals Board (42 C.F.R. Part 426, Subpart D)

Practice Tips

- If no genuine issue of material fact, consider waiving your right to a hearing.
- Medicare is a defined-benefit program, and does not cover all items and services. If a binding authority supports non-coverage, consider whether filing a request for ALJ hearing is in your best interest, and whether any other options (e.g., rebilling, adjustment claims) are still available.
- Examples of services that are non-covered by binding authority include:
  - Enteral and parenteral nutritional therapy for individuals with temporary impairments (does not meet the definition of a prosthetic)
  - Nutritional Supplementation
  - External infusion pumps for administration of vancomycin
  - Implantable infusion pumps for the treatment of thromboembolic disease or diabetes

  NCDs 180.2, 280.14

Practice Tips

- CMS is increasing contractor participation requirements. Be prepared not only to argue your case before an ALJ, but also to respond to questions and testimony from CMS contractors.

- CMS contractors may participate as either a party or as a non-party participant:
  - CMS contractors who elects party status have the same rights as any other party to the hearing, including the right to call witnesses and cross-examine the witnesses of other parties.
  - Non-party status is limited to clarifying issues of fact or policy.

- CMS contractors must notify all parties of their intent to participate no later than 10 calendar days after receipt of the notice of hearing.

42 C.F.R. §§ 405.1010, .1012

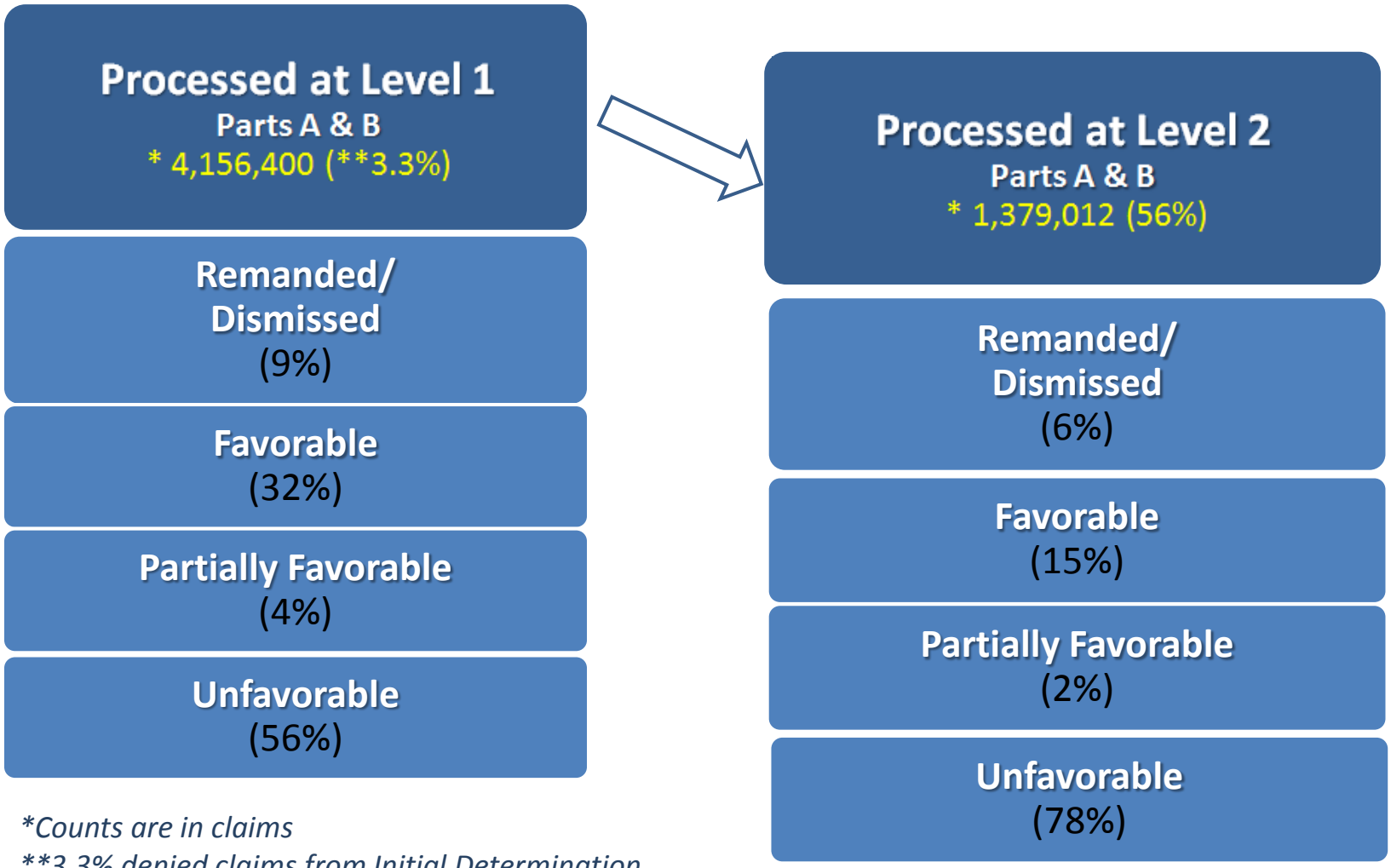
THANK YOU

Medicare Appeals Levels I & II Update

Michael Crochunis
Deputy Director
Medicare Enrollment and Appeals Group
Centers for Medicare & Medicaid Services

Office of Medicare Hearings and Appeals (OMHA) – Medicare Appellant Forum – June 25, 2015 – Arlington, V.A.

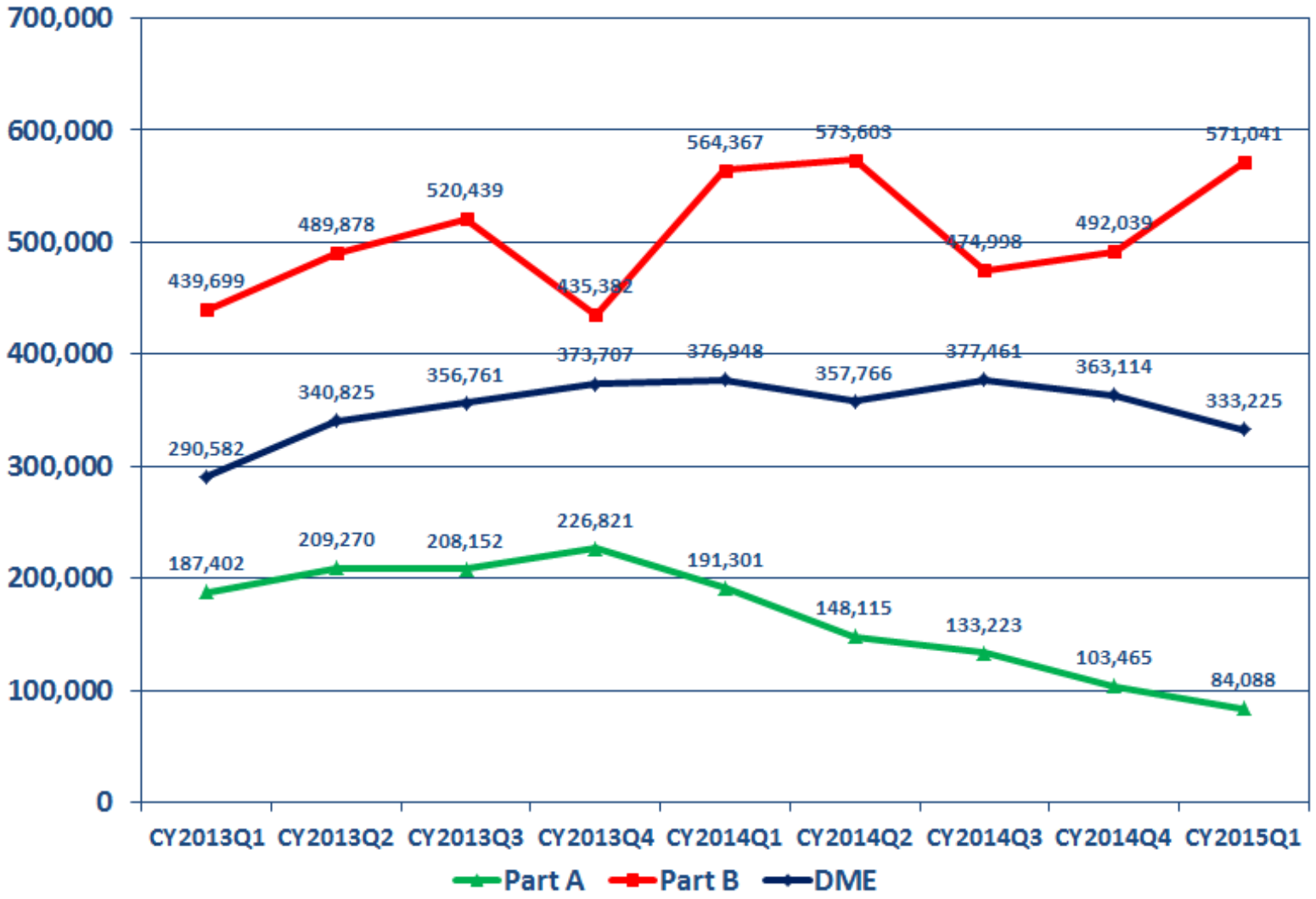
Calendar Year 2014 Appeals Workload



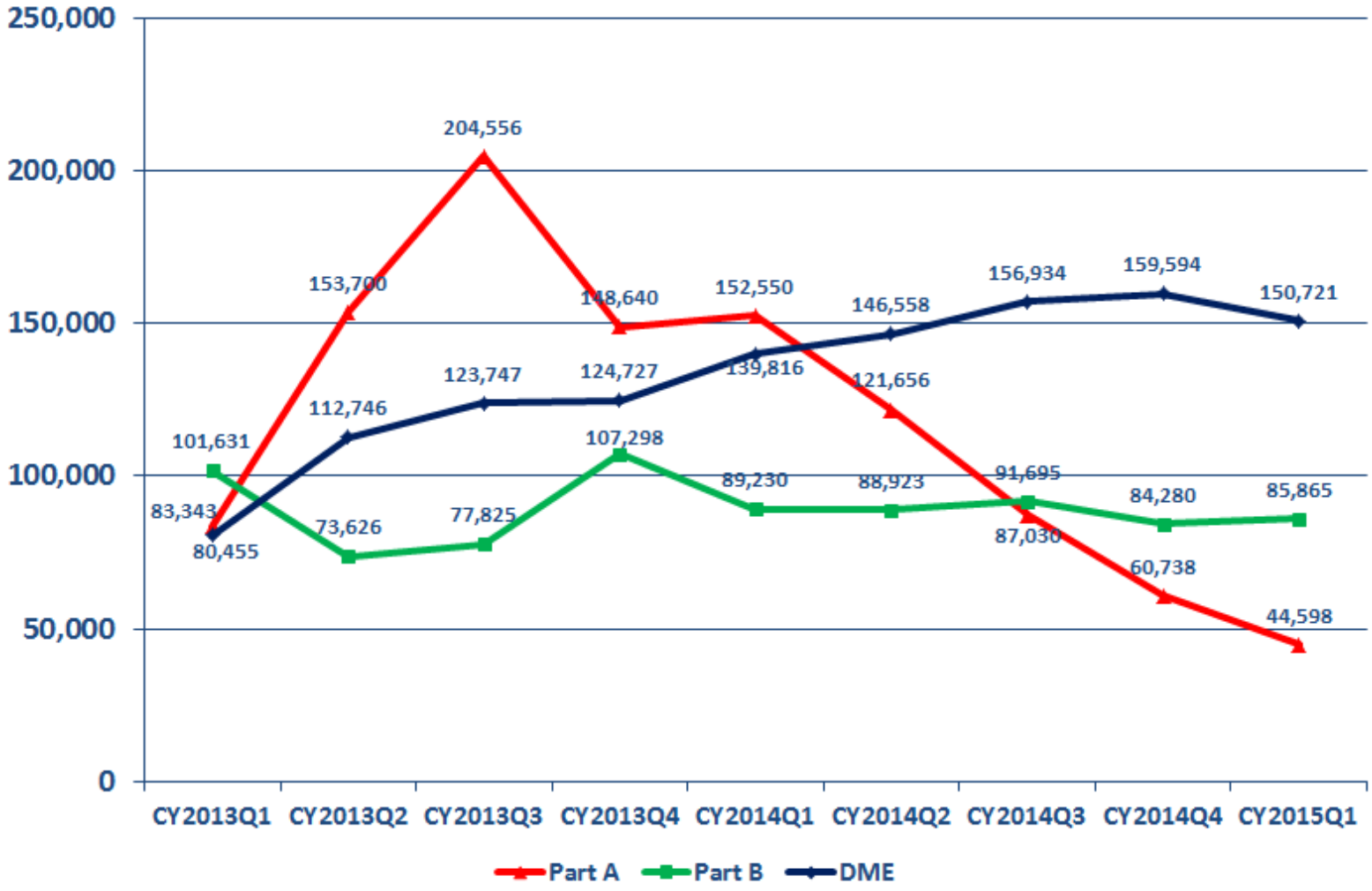
*Counts are in claims

**3.3% denied claims from Initial Determination

Medicare Administrative Contractor Appeals Workload (in claims)



Qualified Independent Contractor Appeals Workload (in claims)



OFM Initiatives to Reduce Provider Burden

OMHA Appellant Forum

Latesha Walker RN, BSN, MS
Provider Relations Coordinator
Centers for Medicare and Medicaid Services
Office of Financial Management, Provider Compliance Group

My Role and Responsibilities

- To improve communications between Medicare FFS Providers and all CMS stakeholders
- Work collaboratively with interested parties to address challenges, complaints, and concerns
- Encourage Medicare FFS providers to work directly with their Recovery Auditor or MAC who conducted the review and use my role to look at process issues
- Educational Suggestions are welcome
- Monitor 2 email boxes
  - RAC@cms.hhs.gov
  - MedicareMedicalReview@cms.hhs.gov

Reduce Provider Burden and Minimize Appeals

1. Prior Authorization
   - PMD… now in 19 states
   - Ambulance…. NJ, PA, SC
   - HBO…. Currently operating in MI, IL and NJ planning underway
   - Chiropractic…2017
   - DMEPOS Regulation coming soon
2. Ensuring Consistency
   - The way contractors conduct reviews
   - Standardized denial reasons
   - Standardized letters
   - Accuracy review of MACs

3. Reducing Provider Burden Efforts
   - Probe and Educate
   - Consistent ADR letters
   - Detailed review results letter
   - Minimize duplicative reviews

   (Not being reviewed by different contractors for the same reason)

Program Update

Jason Green
Director, Program Evaluation and Policy Division
Office of Medicare Hearings and Appeals

http://www.hhs.gov/omha
Medicare.Appeals@hhs.gov

Request for Information

- Consistency in case processing
- Open / revise pilots
- More information on pilots
- Option for abbreviated process
- More resources (adjudicators)

Request for Information

- **Consistency in case processing**
- Open / revise pilots
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OMHA Case Processing Manual

Division I: General Subjects

Division II: Part A/B Claim Determinations

Division III: Part C Organization Determinations

Division IV: Part D Coverage Determinations

Division V: SSA Determinations

Division VI: Reviews of Dismissals (to be developed)

OMHA Case Processing Manual

Division I:

Chapter 1 Manual Overview, Definition, Governance

Chapter 2 General Subjects

Chapter 3 Requests for Case Status, Records, or Information

Chapter 4 Parties

Chapter 5 Representatives

Chapter 6 CMS and CMS Contractor Roles

Chapter 7 Adjudication Time Frames, Case Prioritization, & Escalation

Chapter 8 Special Case Processing Procedures

Chapter 9 Temporary Instructions

OMHA Case Processing Manual

Divisions II through V:

Chapter 1 Request and Correspondence

Chapter 2 Intake Docketing and Assignment

Chapter 3 Procedural Screening

Chapter 4 Administrative Record and Exhibiting

Chapter 5 Issues on Appeals

Chapter 6 Pre-Hearing Case Development and Party-Participant Request and Submissions

Chapter 7 Scheduling and Notices of Hearing

Chapter 8 Conducting the Hearing Post-Hearing Development

Chapter 9 Post-Hearing Development

Chapter 10 Dismissals and Notices of Dismissals

Chapter 11 Decisions and Notices of Decisions

Chapter 12 Remands and Notices of Remands

Chapter 13 Closing the Case

Chapter 14 Post Adjudication Actions

OMHA Case Processing Manual

For the current version:

www.hhs.gov/omha/

Quarterly summary notices:

Federal Register

Understanding Statistical Sampling and Extrapolation

John L. Adams, Ph.D.

Office of Medicare Hearings and Appeals (OMHA) – Medicare Appellant Forum – June 25, 2015 – Arlington, V.A.

Outline

- What is statistical sampling?
- What are the steps in the sampling process?
- How is extrapolation done?

What is statistical sampling?

- Statistical sampling is a name used to underscore that a sample is scientifically designed to support estimation of the original population
- Statistical sampling uses random sampling to ensure that we can extrapolate to the original population
  - Specifically excludes convenience sampling and purposive sampling
  - It doesn't have to be simple random sampling
- Common uses include opinion polls, quality control, medical studies

Chapter 8 of the PIM

The main source of sampling information for Medicare is:

Medicare Program Integrity Manual

Chapter 8 – Administrative Actions and Statistical Sampling for Overpayment Estimates

Step #1: Define the universe and the sampling frame

- The universe is the population for which you would like to estimate the overpayment
  - It could be beneficiaries, particular types of claims, or visits
- The sampling frame is the specific and detailed list of elements we will use to draw the sample
  - This should be well documented and saved

Step #2: Design the sampling plan

- Pick a design
  - Simple random sample
  - Stratified random sample
  - More advanced samples
- Determine the sample size (and allocation if needed)

Step #3: Draw the sample

- It is essential that this be reproducible
- You need software to do this, SAS and RAT-STATS are popular
- It is important to save the computer code and the random number seed(s)
- The sample is then used to determine the overpayments

How is extrapolation done?

- In the case of a simple random sample (overpayment):
  - Calculate the mean (average) overpayment in the sample (X)
  - Calculate the standard error of the mean (SE)
  - Calculate the lower confidence limit (LCL) of a one sided confidence interval: X - t*SE (typically we use the t for a 90% one sided interval)
  - This is the LCL for the average so multiply by the size of the population to get the LCL for the population
- For more complicated sampling designs you need to use statistical software but the logic is the same

HOLD THAT THOUGHT—

QUESTIONS COME LATER

Request for Information

- Consistency in case processing
- Open / revise pilots
- **More information on pilots**
- Option for abbreviated process
- More resources (adjudicators)

Departmental Appeals Board Update
MEDICARE APPEALS COUNCIL

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

The **Medicare Appeals Council (Council)**

is a part of the

Departmental Appeals Board (DAB).

The DAB is a staff division located within the Office of the Secretary.

Medicare Appeals Council

The Council is comprised of:

- Board Chair
- Administrative Appeals Judges
- Appeals Officers
- Members of the Departmental Appeals Board (as needed)

The Council provides the final administrative review for:

- Medicare entitlement
- Fee-for-service claims
- Managed care or prescription drug claims

The Council is supported by the Medicare Operations Division (MOD) attorneys and support staff.

MEDICARE APPEALS COUNCIL: Appeals Process

ALJ Decisions can be appealed by:

- -Provider/Supplier
- -Beneficiary
- -Medicaid State Agency
- -CMS own motion review

Council performs *de novo* review & can take any of the following actions:

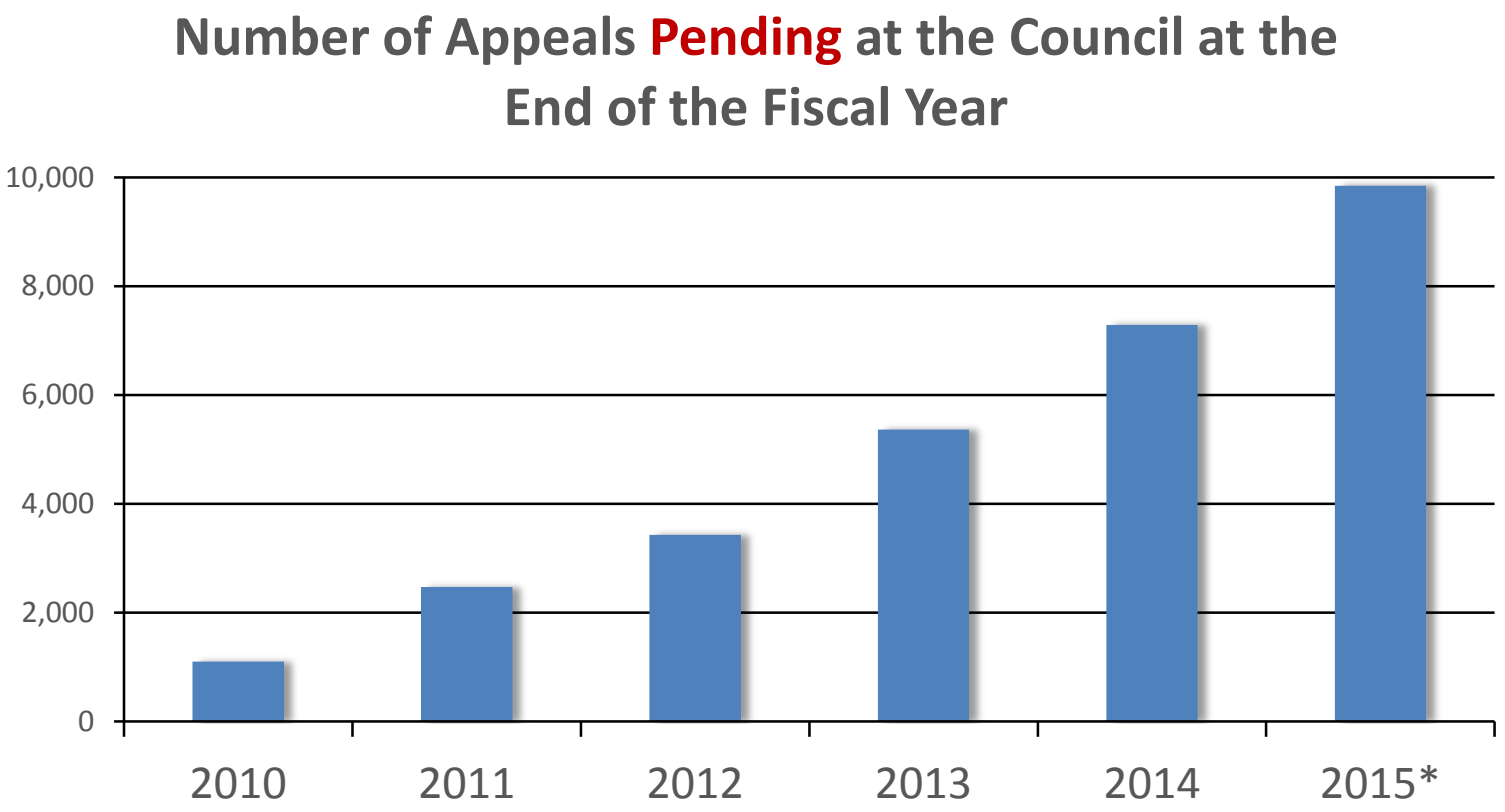
- -Adopt
- -Reverse
- -Modify
- -Dismiss
- -Remand

Council decisions can be appealed to federal court IF the amount in controversy is met ($1,430 in 2014)

Status of Appeals at the DAB

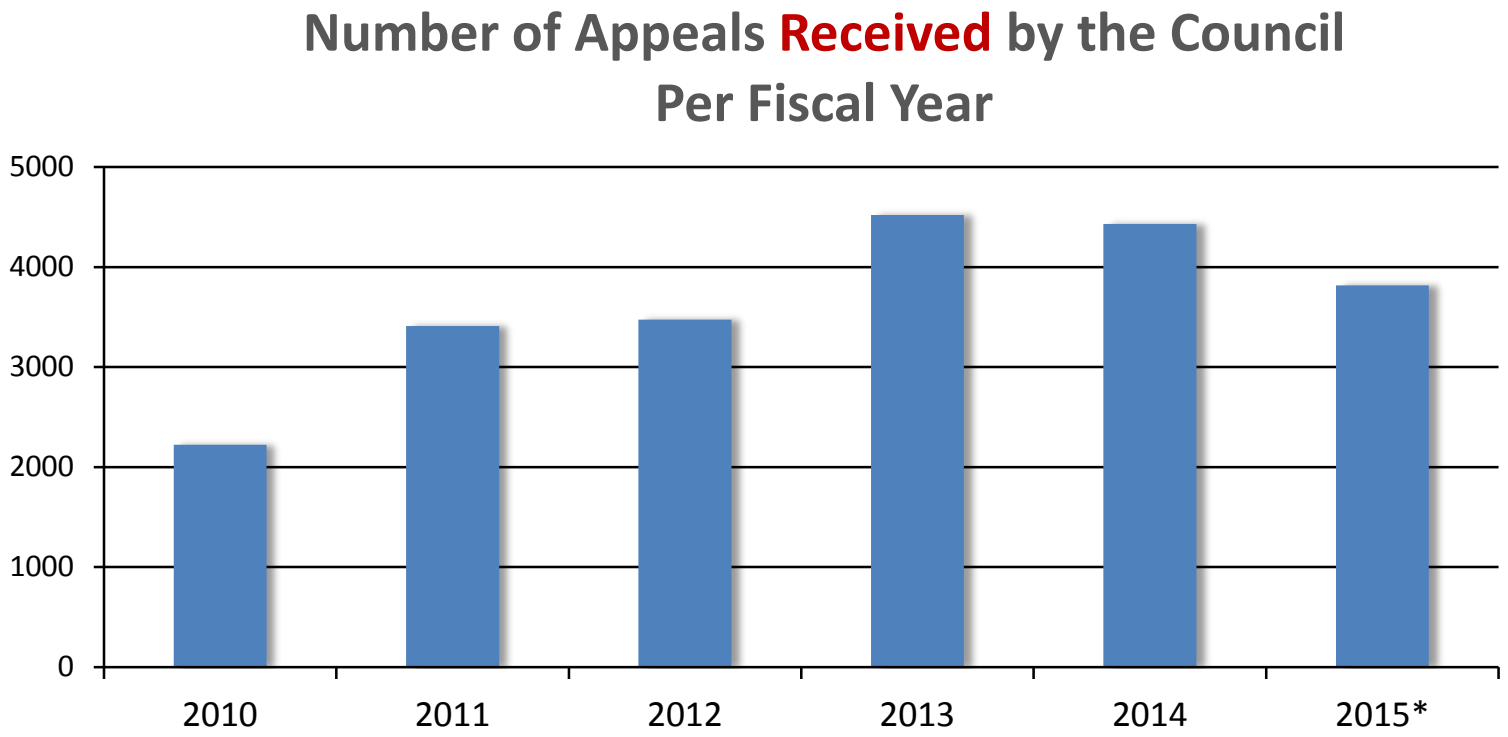
- The number of requests for Council review continues to increase.
- In FY 2014, the Council closed 2,515 appeals (9,838 individual beneficiary claims).
- At the end of FY 2014, the number of pending appeals was approximately 7,290.
- Currently, there are approximately 9,850 appeals pending.
- Beneficiary appeals are being given priority (approximately 7% of the total number of appeals).

Appeals Pending at the Council



*This FY15 number is an estimate as of June 9, 2015

Appeals Received by the Council



*The FY15 number is an estimate as of June 9, 2015

Recent Developments

- Personnel Changes
- Escalation Appeals Officer
- Electronic Filing System
- Electronic Records
- FIDA Demonstration Project
- Office Move

Personnel Changes

Appointment to the Departmental Appeals Board

- Judge Susan S. Yim

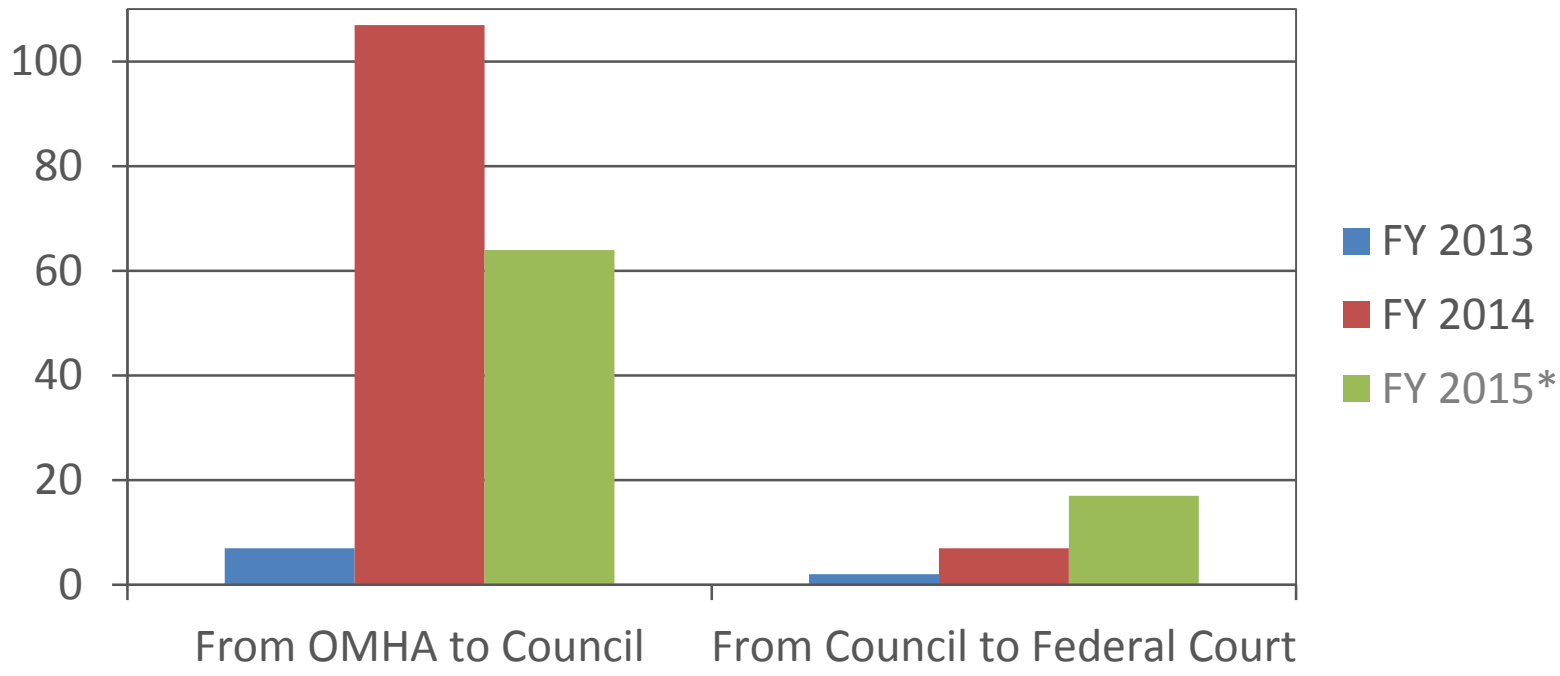
3 New Administrative Appeals Judges:

- Judge Christopher S. Randolph
- Judge Karen R. Robinson
- Judge Deborah S. Samenow

New Management:

- Debbie Nobleman, Director
- Chris Villator, Deputy Director

Escalations



*The FY15 numbers are as of June 9, 2015

Escalation Appeals Officer

- In December 2014, the Escalation Appeals Officer position was created to manage the increasing escalation caseload.
- Initial review of escalation appeals is handled by the Appeals Officer who ensures that the appeal has been properly escalated.
- The Appeals Officer will send an acknowledgment letter to the appellant and depending on whether the appeal has been properly escalated, the Appeals Officer will:
  - Send interim correspondence to the appellant;
  - Send an order to the appellant; OR
  - Remand the appeal to OMHA

Escalation Practice Tip

- If you receive correspondence from the Council re: your escalation appeal, you must respond to the Council by the deadline provided.
- If the Council does not receive a response from you, your appeal will be sent back to OMHA or dismissed.

Electronic Filing System

- Developing an electronic filing (e-file) system so that appellants can file appeals with the Council electronically via the MOD's e-filing website
  - Requests for review will be auto-docketed
  - Streamlines processes
- Similar to the e-file systems already in place in other DAB divisions
- Independent of the Medicare Appeals System (MAS) used by OMHA, QICs, and contractors
- Tentative launch date: before the end of FY 2015

Electronic Filing System

- If an appellant chooses to use e-file, then all correspondence with the Council will be electronic
- The e-file system is currently designed to house:
  - Appellant's request for review
  - Appellant's e-filed correspondence
  - Council-issued documents, including the Council's decision
- Other documents, such as the case file, will not be available in the e-file system.
- At the conclusion of the case, the e-filed documents will be sent electronically to the AdQIC and associated with the master claim file

Electronic Records

- Receiving electronic claim files in cases in which CMS seeks own motion review (Agency Referrals)
- Expanding the use of electronic records to other types of cases, including voluminous box cases.

FIDA Demonstration Project

- FIDA = Fully Integrated Duals Advantage
- Partnership between DAB, CMS, and the State of New York to adjudicate appeals for dually-eligible (Medicaid and Medicare) beneficiaries with a single unified appeals system
  - Reduce beneficiary confusion
  - Speed access to appropriate services
  - Generate administrative savings
- The Council will perform the final level of administrative review
- FIDA appeals will be entirely e-file

DAB Office Move

- The DAB's office will be moving to the SW complex
- Move date is scheduled for December 12, 2015
- In the days before and after the move date, appellants may be impacted by the disruption to the staff's ability to open the mail, check e-mail, voicemail, etc.
- Address and phone numbers will remain the same

HOLD THAT THOUGHT—

QUESTIONS COME LATER

Thank you for participating in OMHA Medicare Appellant Forum.

If you have additional questions submit them via email to
OSOMHAAppellantForum@hhs.gov

For press inquiries, please contact :

Carla Daniels
Public Affairs Specialist, ASPA
202-690-4595
Carla.Daniels@hhs.gov