OMHA Case Processing Manual

Chapter 16 DECISIONS

Section Title

16.0 Chapter overview

(Issued: 10-09-19, Effective: 10-09-19)

This chapter addresses the structure and content of decisions issued by OMHA adjudicators. A written decision states the facts of a case, conclusions of law, and rationale for the adjudicator's decision. This chapter also addresses notices of decision, which accompany each decision issued and explain the parties' appeal rights and other possible actions. Finally, this chapter discusses the effect of a decision and situations when a decision may be reopened or amended.

Caution:	When taking the actions described in this chapter, ensure that all PII, PHI, and Federal Tax Information is secured and only disclosed to authorized individuals (internally, those who need to know).

16.1 Before drafting a decision

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16.1.1 What actions must be completed before drafting a decision?

Before drafting a decision, the adjudicator will consider the evidence and testimony, if a hearing was held, in light of applicable law and policy. The adjudicator will then draft the decision, or provide instructions for drafting the decision, as applicable.

16.1.2 What do decision drafting instructions include?

The ALJ considers the record, identifies the determinative facts and law, and determines the outcome of the issues. After weighing the evidence that is being considered and any hearing testimony, and considering the relevant authorities and any applicable program guidance, the ALJ drafts instructions that include the decision outcome and underlying rationale for the decision, with reference to the evidence or testimony relied upon, as appropriate.

There is no required format for decision instructions, but they should provide clear guidance to the decision drafter as to the determination on every issue and the evidence or testimony relied upon, as appropriate. In addition, the decision drafting instructions must include the following:

- Rulings on evidentiary issues that were not resolved before the close of the hearing, so they can be included in the decision;

> *Example*: During a hearing, the appellant asked to submit new evidence subject to a good cause determination. The ALJ granted the request and held the record open after the hearing. The decision instructions must include the ALJ's good cause ruling on the new evidence.

- Determinations related to weight of evidence, persuasiveness of argument, and credibility of witnesses;

> *Example*: An ALJ hears testimony on the credentials of an expert witness, makes determinations on the credibility of the witness and the weight to give the testimony, and includes these determinations in the decision instructions.

- Determinations of financial responsibility, if applicable, including whether any limitation on liability or waiver of overpayment recovery provisions apply; and
- Specific testimony or arguments, offered by a party or participant at the hearing, that the ALJ wants to be characterized and addressed in the written decision.

Additionally, it may be helpful to include:

- Names and titles of hearing participants and, if attended by a CMS contractor, the contractor's election status (i.e., Party or Non-Party Participant);
- Unresolved issues of law for which the ALJ requests additional research and follow up discussion from the decision drafter; and
- Exhibit references to specific documents the ALJ felt were central to the analysis.

16.2 Characterizing the outcome of a decision

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16.2.1 What are possible characterizations of a decision?

Characterize the outcome of a decision as one of the following:

- A "**favorable**" or "**fully favorable**" decision means the decision is decided in the appellant's favor with respect to every issue related to coverage and payment rules, or the application of eligibility, entitlement, or premium rules, that is before the adjudicator, **as compared to the outcome in the appealed reconsideration**.
- An "**unfavorable**" decision means the decision is not decided in the appellant's favor with respect to any issue related to coverage and payment rules, or the application of eligibility, entitlement, or premium rules, before the adjudicator, **as compared to the outcome in the appealed reconsideration**.
- A "**partially favorable**" decision means that some, but not all, of the issues related to coverage and payment rules, or the application of eligibility, entitlement, or premium rules, that are before the adjudicator are decided in the appellant's favor, **as compared to the outcome in the appealed reconsideration**.

> *Example*: The following are examples of partially favorable decisions:
>
> - The decision is fully favorable with respect to certain items or services at issue, but unfavorable with respect to other items or services at issue in the same request for hearing (or in a consolidated request for hearing for which a consolidated decision is issued).
> - The decision is that one or more items or services at issue are covered at a partial or down-coded rate of payment from the amount originally billed, *except* if a CMS contractor already approved payment at a partial or down-coded rate, and the adjudicator determines the down coding was correct, the decision is unfavorable because the only issue before OMHA (whether the item or service is covered and payable as billed) was decided unfavorably for the appellant, and no additional payment has been awarded.
> - The decision is that some, but not all, of the charges remaining in an MSP recovery action were unrelated to the beneficiary's settlement.

- The decision is that the beneficiary continued to require and receive skilled nursing services for some, but not all, of the days during which the beneficiary remained a resident of a skilled nursing facility after the facility determined Medicare coverage would end.
- The decision is that none of the individual sample claims associated with an extrapolated overpayment were covered, but the statistical sampling methodology was invalid, and the results of the sample review cannot be extrapolated to the universe.

- "**Affirmed**" is used only in the context of a **request for review of a dismissal**,[1] and means that the OMHA adjudicator upheld the dismissal of the reconsideration request.

Caution: If payment for the same item or service is contingent on a favorable resolution of more than one requirement, if any of those requirements is decided unfavorably, the disposition is still unfavorable, even if one or more of the other requirements is decided favorably for the appellant.

Example: In an appeal involving a denied claim for home health services, two of the issues before the adjudicator are: (1) whether the beneficiary was homebound; and (2) whether the beneficiary was in need of skilled services. If either one of these issues is decided unfavorably for the appellant, the decision is characterized as "unfavorable," not "partially favorable."

16.2.2 What do we consider when characterizing a decision as fully favorable, unfavorable, or partially favorable?

Generally, decisions are characterized with respect to all of the issues related to Medicare coverage and payment rules or the application of eligibility, entitlement, or premium rules, **as compared to the outcome in the appealed reconsideration**.

- Generally, a decision that requires **additional disbursement** from the Medicare trust fund (or that reduces the amount of a premium or overpayment recovery) based on the application of coverage and payment rules, or eligibility, entitlement, or premium rules is characterized as "**fully favorable**" or "**partially favorable**."

[1] Because OMHA ALJs and attorney adjudicators conduct *de novo* reviews, a disposition of "affirmed," "reversed," or "modified" is never an appropriate disposition on a request for an ALJ hearing.

- Generally, a decision that awards **no additional payment** (or that does not reduce the amount of a premium or overpayment recovery) based on the application of coverage and payment rules, or eligibility, entitlement or premium rules is characterized as "**unfavorable**."

Caution:	In decisions involving a determination related to financial responsibility for a denied claim, characterize the decision with respect to the outcome of the coverage and payment rule determinations for the item(s) or service(s) at issue, regardless of whether payment is made or the liability of a party is limited pursuant to section 1879 of the Act, recovery of an overpayment is waived pursuant to section 1870, or the outcome of another provision related to financial responsibility for a denied claim. See OCPM 16.2.4 for more information.

16.2.3 How do we characterize a decision that involves a claim with multiple claim line items?

For appeals involving claims for items or services, characterize the outcome of the decision based on the outcome of the claims that are at issue before the OMHA adjudicator, not the individual claim line items. Do this even where an appellant concedes that part of the claim is non-covered.

Example:	A claim for a wheelchair base and accessories is denied at all lower levels of appeal. The appellant contests the QIC's determination with respect to the base, but concedes that the accessories were non-covered. Because the wheelchair and accessories were billed on the same claim, and both were decided unfavorably below, both are at issue under 42 C.F.R. section 405.1032. If the OMHA adjudicator determines that only the base is covered, the decision is "partially favorable," not "fully favorable."

Example: The appellant submits two claims for two consecutive 60-day episodes of home health care provided to the same beneficiary from January 1 through March 1, 2015, and from March 2 through April 30, 2015. The QIC denies both episodes under a single Medicare appeal number. The appellant files a single request for hearing that lists dates of service January 1 through March 1, 2015, only. Because the appellant has requested a hearing with respect to the first episode of care only, only that claim is at issue before the ALJ. Therefore, if the ALJ determines that the appealed claim is covered, the decision is "fully favorable," not "partially favorable."

Note: The decision should convey that the QIC reconsideration included another claim for a subsequent episode of care, but the appellant requested a hearing with respect to the first episode only. If the claim for the subsequent episode was promoted in the case processing system, it must be disassociated before closing the appeal.

16.2.4 What is the effect of financial responsibility determinations on the characterization of the decision?

When an appellant requests an ALJ hearing on a denied claim, whether Medicare coverage and payment criteria are met for the item(s) or service(s) are the threshold issues before the OMHA adjudicator that determine how the decision is characterized (*see* OCPM 16.2.2). If the adjudicator determines that Medicare coverage or payment criteria have not been met, financial responsibility for the cost of the non-covered item or service is an ancillary issue that must be addressed in the decision, but it does not affect the characterization of the decision as "unfavorable" or "partially favorable."

Example: The appellant, an ambulance supplier, requests a hearing challenging the QIC's determination that the supplier was financially responsible for the cost of non-covered ground ambulance services. Although the appellant does not contest the QIC's finding of non-coverage, Medicare coverage of the ambulance services is still an issue per 42 C.F.R. section 405.1032. The ALJ concludes that, based on the evidence and testimony, the ambulance services were non-covered, and the beneficiary is financially responsible for the cost of the non-covered services. Although the appellant is relieved of financial responsibility, the disposition in this case is "unfavorable" because the ALJ's decision with respect to Medicare coverage was unfavorable.

When Medicare payment is made pursuant to the limitation on liability provisions of section 1879 of the Act, or recovery of an overpayment is waived (or refunded if the overpayment was already collected) pursuant to the waiver of overpayment recovery provisions of section 1870 of the Act, the decision is characterized as "unfavorable." This is because in such cases, the adjudicator has determined that Medicare coverage and/or payment criteria were not met, even though payment must be made or a recouped overpayment must be refunded notwithstanding the unfavorable finding.

Example: An appellant-provider requests a hearing with respect to a denied clinical diagnostic laboratory test, arguing that the test was covered under Medicare. The ALJ determines that, based on the evidence and testimony, the test is non-covered because it is not reasonable and necessary, but neither the beneficiary nor the appellant could reasonably have been expected to know that Medicare payment would not be made and, therefore, Medicare payment must be made pursuant to section 1879 of the Act. Although the ALJ ordered payment under section 1879 of the Act, the disposition in this case is characterized as "unfavorable."

Example: The ALJ determines that, based on the evidence and testimony, all conditional payments at issue in an MSP appeal were related to the beneficiary's settlement, and Medicare had a right to recover the overpayment. However, the ALJ determines that the beneficiary is entitled to a partial waiver of recovery under section 1870 of the Act because the beneficiary is without fault and recovery of the full amount would be against equity and good conscience. The disposition in this case is "unfavorable" because the ALJ determined that Medicare's conditional payments were related to the beneficiary's settlement and Medicare's recovery action was valid.

16.3 Decision content and format

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If a **request for hearing** is not dismissed or remanded, the adjudicator issues a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision.[2] The decision is based on the administrative record, including any evidence or testimony presented at hearing, if one was held.

If a request for **review of a dismissal** of a reconsideration request is not dismissed or remanded, the adjudicator issues a written decision affirming the dismissal.[3] See OCPM 16.4.1 for the format of a decision affirming a dismissal.

The OMHA Decision template (OMHA-152) provides a consistent structure and allows for easy reading with uniform margins and section titles, as well as consistent header and footer information. Within each section, the decision template includes prompts for all of the required elements for a decision issued by an OMHA adjudicator.

16.3.1 What are the contents of a decision?

An OMHA decision on a request for hearing (and the accompanying notice of decision) must be written in a manner calculated to be understood by a beneficiary and must include:[4]

- The specific reasons for the decision, including, to the extent appropriate, a summary of any clinical or scientific evidence used in making the decision;
- For any new evidence that was submitted for the first time at the OMHA level and subject to a good cause determination pursuant to 42 C.F.R. section 405.1028, a discussion of the new evidence and the good cause determination that was made;
- The procedures for obtaining additional information concerning the decision; and
- Notification of the right to appeal the decision to the Council, including instructions on how to initiate an appeal.

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[2] 42 C.F.R. §§ 405.1046(a)(1), 423.2046(a)(1).
[3] 42 C.F.R. §§ 405.1046(b)(1), 423.2046(b)(1).
[4] 42 C.F.R. §§ 405.1046(a)(2), 423.2046(a)(2) (Providing the contents of the written notice of decision. For OMHA's purposes, the written notice of decision includes the Decision (OMHA-152), and the accompanying Notice of Decision (OMHA-1051) or Notice of Decision Affirming Dismissal (OMHA-150).)

16.3.2 What writing guidelines should decision drafters follow?

Decisions must fulfill the legal requirement that they are written in a manner calculated to be understood by a beneficiary.[5] Thus, they must use language and explanations that are understandable by a beneficiary. To help ensure a beneficiary and the intended recipients can understand the decision, use plain language where possible, and employ clear writing techniques.

- Using **first-person and second-person active voice** is a best practice for clear writing and eliminates the ambiguity and confusion that can result from using passive voice.

> *Example:* *(First-person, active voice)*—After considering the evidence and arguments presented in the record, I issue a fully favorable decision.
>
> *Example:* *(Passive voice)* ***(avoid)***—After considering the evidence and arguments presented in the record, a fully favorable decision is entered.
>
> *Example:* *(Second-person, active voice)*—You must include the following information in your response.
>
> *Example:* *(Passive voice)* ***(avoid)***—The following information must be included in the response for it to be considered complete.

- **Spell out acronyms**, initialisms, and other abbreviations on first use.

> *Example*: The Qualified Independent Contractor (QIC) issued an unfavorable decision.

- Explain relevant terms that may not be familiar. If a definition is necessary, cite to a medical dictionary or other reputable source.
- Keep sentences simple and direct.
- Use “must” instead of “shall” for an obligation, “must not” for a prohibition, “may” for a discretionary action, and “should” for a recommendation.
- Be concise—leave out unnecessary words.

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[5] Section 1869(d)(4) of the Act; 42 C.F.R. §§ 405.1046(a)(2), (b)(2), 423.2046(a)(2), (b)(2).

Additional information on Federal plain language guidelines can be found at Plainlanguage.gov.

16.3.3 How do we protect beneficiary and enrollee PII and PHI in a decision?

In the **caption** of the decision, use the beneficiary's or enrollee's first initial, last name, and truncated (partially masked) Medicare number (HICN or MBI).

In the **body** of the decision, beneficiary and enrollee PII and PHI should be limited.

- Use the term "beneficiary" or "enrollee" instead of using names or gender-specific pronouns.
- Characteristics of the beneficiary or enrollee, or beneficiaries or enrollees, should be limited to only those relevant to the decision.
- Identifiers such as general health conditions, age, and residence should not be included *unless* relevant to the decision.

If the appeal includes multiple beneficiaries, create a multiple-beneficiary / multiple-claim list using Attachment A (OMHA-ATT) and include it with the decision. The attachment should contain a list of beneficiaries identified by first initial and last name, a truncated Medicare number (HICN or MBI), and the date(s) of service, if applicable.

16.3.4 What is the format of a decision?

A complete written decision typically contains the following sections:

- Decision (*see* OCPM 16.3.5);
- Procedural history (*see* OCPM 16.3.6);
- Issues (*see* OCPM 16.3.7);
- Applicable law and policy (*see* OCPM 16.3.8);
- Findings of fact and analysis (*see* OCPM 16.3.9);
- Conclusions of law (*see* OCPM 16.3.10); and
- Order (*see* OCPM 16.3.11).

Some types of decisions (for example, stipulated decisions and decisions affirming the dismissal of a reconsideration request) may use an abbreviated format (*see* OCPM 16.4).

16.3.5 What is included in the decision section?

At the beginning of each decision, a summary of the decision describes the outcome and ultimate disposition of the appeal. The contents of this section may vary depending on the type of appeal and the issue(s) presented.

Claim appeals

Identify the item(s) or service(s) at issue, the outcome related to Medicare coverage and payment, and the party that bears financial responsibility for any non-covered costs, if applicable.

> *Example*: After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The ambulance services at issue are non-covered under section 1861(s)(7) of the Social Security Act because transportation by other means was not contraindicated. As such, the beneficiary is financially responsible for the cost of the non-covered ambulance services.

Part C or Part D requests for coverage

Identify the item, service, or drug for which Medicare coverage was sought, and the adjudicator's finding regarding coverage.

> *Example*: After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The Part D plan is not required to cover oral iron supplementation for the enrollee because prescription vitamins and minerals are excluded from Medicare coverage.

Hospital discharge appeals and provider service terminations

Identify the discharge or termination the appellant is challenging, and the adjudicator's finding regarding the discharge or termination.

> *Example*: *Part A termination*. After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The provider appropriately terminated SNF services because the beneficiary no longer required skilled nursing or rehabilitation services. The beneficiary is financially responsible for SNF services received after the termination date.

Example: *Part C termination*. After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The provider appropriately terminated SNF services because the enrollee no longer required skilled nursing or rehabilitation services, and there is no evidence the enrollee continued to receive skilled services after the termination date.

Part D requests for prior authorization or tiering exceptions

Identify the drug at issue, the action the appellant is seeking from the Part D plan, and the adjudicator's finding regarding the action.

Example: After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The Part D plan sponsor is not required to pre-authorize the requested drug for the enrollee because the drug was not prescribed for a medically accepted indication.

MSP recovery actions

Identify the Medicare Secondary Payer recovery at issue, and the adjudicator's finding regarding repayment.

Example: After considering the evidence and arguments presented in the record, I enter a **FULLY FAVORABLE** decision. The Medicare recovery claim against the appellant's settlement proceeds consists entirely of charges that are unrelated to the medical negligence settlement and not subject to repayment pursuant to the Medicare Secondary Payer provision of section 1862(b) of the Social Security Act.

Eligibility and entitlement appeals

Identify the enrollment or entitlement issue, and the adjudicator's finding regarding the enrollment or entitlement.

Example: After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. The beneficiary failed to enroll in Medicare Part B during the initial enrollment period and must now wait for the next general enrollment period to enroll.

Premium appeals

Identify the premiums at issue, and the adjudicator's finding regarding the premiums.

> *Example*: After considering the evidence and arguments presented in the record, I enter an **UNFAVORABLE** decision. SSA properly assessed a Medicare Part B premium surcharge for late enrollment, and there is no basis for granting equitable relief from the surcharge.

16.3.6 What is included in the procedural history section?

The procedural history of the case identifies the previous actions that brought the case to this point in the appeals process, up to and including the filing of a request for hearing, and cites to applicable portions of the administrative record. This section typically:

- Identifies the items or services at issue. If the appeal involves a claim denial, the description typically includes the dates of service and any specific procedure codes at issue in the appeal;

  > *Example*: The appellant submitted a claim for ambulance service, basic life support, non-emergency transport (HCPCS code A0428) and 9.5 ground miles (HCPCS code A0425), provided to the beneficiary on February 5, 2019. (File 1, p. 15). . . .
  >
  > *Note*: If numerous procedure codes are at issue, the services may be summarized in this section without reference to the specific codes. For example, in an appeal involving multiple outpatient physical and occupational therapy modalities, the description of the items and services at issue may simply reference "physical and occupational therapy services" and the dates of service at issue.

- Describes the outcome of the initial determination and prior levels of appeal, including findings concerning financial responsibility for non-covered services. The names of specific CMS contractors or plans, and the dates of and reasons for the lower-level determinations, may, but are not required to be, included.

  > *Example*: The Medicare Administrative Contractor denied payment for the ambulance services upon initial determination and redetermination. (File 1, pp. 3–4). The Qualified Independent Contractor upheld the

denial and found the beneficiary financially responsible for the non-covered services. (File 1, pp. 6–8).

Example: On March 1, 2018, First Coast Service Options (First Coast), the Medicare Administrative Contractor with jurisdiction, denied payment for ambulance services upon initial determination. (File 1, pp. 40–47). First Coast issued an unfavorable redetermination decision on May 15, 2018, upholding the initial determination. (File 1, pp. 35–40). The Qualified Independent Contractor, C2C Solutions, Inc. (C2C), issued an unfavorable reconsideration decision on August 8, 2018, finding that coverage was excluded under section 1861(s)(7) of the Social Security Act because transportation by other means was not contraindicated. (File 1, pp. 1–6). C2C found the beneficiary financially responsible for the excluded ambulance services. (*Id.*).

- States that a request for hearing was received, and includes a discussion of any filing defects or other threshold jurisdictional issues that were resolved.

Note: The date the request for hearing was received, AIC, and other threshold jurisdictional issues do not need to be included in this section, *unless* timeliness of the request, AIC, or other jurisdictional issues were initially present in the appeal.

Example: *No jurisdictional issues present*. The appellant filed a valid request for hearing. (File 3, pp. 1–2).

Example: *Timeliness of request initially at issue*. The beneficiary filed a request for an Administrative Law Judge hearing that was received by OMHA on March 15, 2018, 72 days after the date of the reconsideration decision. (File 3, pp. 1–2). With the request, the beneficiary included a hospital discharge summary showing he had been hospitalized from March 1 through March 9, 2018, and a letter explaining that, due to the hospitalization, he was unable to file his request for hearing before the March 8, 2018, deadline. (File 3, pp. 3–6). The regulations at 42 C.F.R. section 405.1014(e) (referencing section 405.942(b)(2) and (3)) provide that good cause may be found for missing the deadline to file a request for hearing when a party was prevented by serious illness from contacting OMHA in person, in

> writing, or through a friend, relative, or other person. As such, good cause exists to extend the filing deadline in this case.

- Identifies whether any hearings or conferences were held.

  If any **conferences or hearings were held**, identify the date each conference or hearing was held and the names and titles/organizations, if applicable, of the parties or participants who attended.

  If a **hearing was <u>not</u> held**, identify the regulatory basis on which a decision was able to be issued without a hearing.

> *Example*: I conducted a prehearing conference on March 18, 2018. Dr. Anna Jones represented the appellant and Michael Smith, R.N., appeared on behalf of the QIC. On April 3, 2018, I conducted a telephone hearing. Dr. Jones attended the hearing and provided testimony on behalf of the appellant, and Mr. Smith appeared on behalf of the QIC, which had elected party status in this appeal. (Hearing Audio).
>
> *Example*: The appellant-beneficiary indicated in writing that he waived his right to an ALJ hearing and requested this case be decided on the record without a hearing. (File 3, pp. 4–5). Pursuant to 42 C.F.R. section 405.1038(b)(1)(i), an adjudicator may decide a case on the record without conducting an oral hearing if all the parties who would be sent a notice of hearing in accordance with section 405.1020(c) indicate in writing that they do not wish to appear before an ALJ at a hearing. The appellant-beneficiary is the only party who would be sent a notice of hearing. Accordingly, I am issuing this decision without conducting a hearing.
>
> *Example*: Pursuant to 42 C.F.R. section 405.1038(a), an adjudicator may decide a case on the record without conducting an oral hearing if the decision is fully favorable to the appellant on every issue and no other party to the appeal is liable for the claims at issue. Accordingly, I am issuing this fully favorable decision on the record without conducting a hearing.

- Includes a description of any new evidence that was submitted and subject to a good cause determination, and a discussion of whether the adjudicator found

good cause to admit the new evidence.[6] If the evidence was admitted, the substance of the evidence is addressed in the findings of fact and analysis section.

> *Example*: With its request for hearing, the appellant submitted new evidence that had not been submitted to a previous decision-maker. The evidence consisted of additional medical records, and included a statement explaining that the QIC denied coverage on a different basis than the one identified by the MAC, so the appellant was previously unaware that the information in the additional medical records was relevant to the coverage determination. Pursuant to 42 C.F.R. section 405.1028(a)(2)(i), I determined that there was good cause to admit the new evidence to the administrative record.
>
> *Example*: With its request for hearing, the appellant submitted several pages of medical records that had not been submitted to a previous decision-maker. The appellant also submitted a statement explaining that the provider had forgotten to include the medical records in the original appeal. In accordance with 42 C.F.R. section 405.1028, an ALJ must examine any new evidence submitted by a provider, supplier, or beneficiary represented by a provider or supplier to determine whether there is good cause for submitting the new evidence for the first time at the ALJ level. I determined that there was not good cause for submitting the new documentation for the first time at the ALJ level. Therefore, the evidence is excluded, and I did not consider it in rendering this decision.

- If necessary, addresses the admission of exhibits into the administrative record.

> *Note*: Because the disposition package for exhibited cases contains a copy of the index of the administrative record (*see* OCPM 19.2.2), it is only necessary to address the admission of exhibits into the administrative record when there is an objection about whether an exhibit should be admitted.

- Includes other procedural matters, as applicable, such as:

[6] *See* 42 C.F.R. §§ 405.1018, 405.1028.

- Description of hearing postponements or supplemental hearings;
- Description of prior proceedings if an appeal was reopened;
- Description of any aggregation to meet the amount in controversy, including the OMHA appeal number(s) of any related appeals that were not combined with the current appeal;
- Description and, if necessary, ruling on any ad hoc procedural issues, such as objections to the inclusion of new issues, or the participation of a CMS contractor;
- Description of appeal combinations that were made; or
- Description of any interpreter or translation services provided.

16.3.7 What is included in the issues section?

The issues section identifies all the issues in the appeal, including financial responsibility, where applicable. The issues may be presented in either paragraph or numbered form, depending on the adjudicator's preference.

Although the notice of hearing includes a general statement that the issues before the ALJ include all of the issues brought out in the initial determination, redetermination, or reconsideration that were not decided entirely in a party's favor (*see* OCPM 14.5.1), the statement of the issues in a decision must describe **all issues with specificity**—not just new issues the ALJ considers pursuant to 42 C.F.R. section 405.1032(b) or 423.2032(b).

Example: In an appeal involving a claim for outpatient physical and occupational therapy services denied as not medically necessary, the statement of the issues might read as follows:

1. Whether the outpatient physical and occupational therapy services provided to the beneficiary from March 1, 2017 through March 14, 2017, were reasonable and necessary in accordance with section 1862(a)(1)(A) of the Social Security Act (Act).
2. If the services are found to be excluded under section 1862(a)(1)(A) of the Act, whether the provider's or beneficiary's liability, or both, may be limited under section 1879 of the Act.

Note: An adjudicator may consider a <u>new</u> issue at a hearing only if all parties who were or will be sent the notice of hearing are notified of the new issue prior to the start of the hearing. If a new issue is discovered during the drafting of

the decision, the adjudicator must provide the parties with an opportunity to address the issue.[7]

16.3.8 What is included in the applicable law and policy section?

This section identifies the principles of law and policy applicable to the case. This includes binding authorities, such as statutes, regulations, NCDs, and precedential decisions of the Council, as well as non-binding program guidance issued by CMS or SSA, such as CMS manual instructions or LCDs.[8] Only the **relevant portions** of applicable laws and policies should be discussed or reproduced.

It is not necessary to discuss laws that:

- Establish OMHA's jurisdiction and the authority of the OMHA adjudicator to issue a decision;
- Define the scope of an OMHA adjudicator's review (that is, the issues the adjudicator may consider); or
- Define the *de novo* standard of review.

Note: Although it is not necessary to include law and policy establishing jurisdiction and the scope or standard of review, short summaries may be included.

Example: An enrollee who is dissatisfied with an IRE's reconsideration may request a hearing before an ALJ when jurisdictional requirements are met. *See* 42 C.F.R. § 423.2002. An OMHA adjudicator conducts a *de novo* review of the case. 42 C.F.R. § 423.2300(d).

Example: A party to an IRE's dismissal of a request for reconsideration may request that an ALJ or attorney adjudicator review the dismissal when certain jurisdictional requirements are met. *See* 42 C.F.R. § 423.2004.

[7] 42 C.F.R. §§ 405.1032(b), 423.2032.

[8] LCDs are generally non-binding on OMHA adjudicators. However, Council decisions have held that in Part C cases, because the LCD is binding on the plan, they are also binding on subsequent reviewers. *See*, *e.g.*, M-18-6264, M-18-6305, M-18-5068.

16.3.9 What is included in the findings of fact and analysis section?

16.3.9.1 What are findings of fact?

Findings of fact are facts the adjudicator finds to be accurate and supported by the evidence in the record.[9] Findings of fact are based on the complete record, including testimony, exhibits, official documents, and any other evidence admitted into the record, and may also include well-known and indisputable facts of which the adjudicator takes judicial notice. Application of the relevant legal authorities to the findings of fact constitutes the analysis and forms the basis for the adjudicator's conclusions of law.[10]

16.3.9.2 What is included in the analysis?

General analysis

The analysis section applies the applicable legal standards to the findings of fact. The analysis must address each issue that needs to be resolved to decide the appeal. The analysis must fully explain why the facts and the applicable law and policy logically and reasonably lead to the adjudicator's conclusions of law.

In general, the analysis should identify any specific Medicare coverage and payment criteria necessary to resolve the issue(s) on appeal, and discuss how the facts of the case meet, or fail to meet, each identified requirement.

Financial responsibility analysis

For hearing requests resulting from a denied or partially denied claim, if the adjudicator determines that Medicare coverage or payment criteria have not been met, or that an item or service is not a Medicare-covered benefit, financial responsibility for the cost of the denied item or service is an ancillary consideration that must be decided. Financial responsibility must be assessed with respect to any applicable statutory provisions, including but not limited to:

- Statutory exclusions from coverage, which generally result in beneficiary liability;
- The limitation on liability provisions of section 1879 of the Act;
- The waiver of overpayment recovery provisions of section 1870 of the Act;

[9] *Finding of Fact*, Black's Law Dictionary (11th ed. 2019).
[10] *See Findings of Fact and Conclusions of Law*, Black's Law Dictionary (11th ed. 2019).

- Refund requirements for non-assigned claims for physician services under section 1842(l) of the Act;
- Specific limitations on charges under the Part A Provider Agreements set forth under 42 C.F.R. section 489.21; and
- Refund requirements for assigned or non-assigned claims for medical equipment and supplies under sections 1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

Note: Liability cannot be assessed against "the appellant" in cases where a Medicaid State Agency is appealing the claim pursuant to 42 C.F.R. section 405.908.

Note: For cases in which the limitation on liability provisions of section 1879 of the Act and the waiver of overpayment recovery provisions of section 1870 both apply, liability must first be assessed under section 1879 because, if payment is made pursuant to section 1879, no overpayment exists.

Note: In cases where the adjudicator has determined that Medicare coverage criteria were not met, but payment may be made pursuant to the limitation on liability provisions of section 1879 of the Act or the waiver of overpayment recovery provisions of section 1870 of the Act, the decision outcome is characterized as unfavorable (*see* OCPM 16.2.4.).

16.3.9.3 How do we present findings of fact and analysis?

Findings of fact and analysis may be presented sequentially (that is, all findings of fact may be presented first, followed by a separate analysis), or the findings of fact may be incorporated into the analysis. When findings of fact are presented separately, they may be presented in either paragraph or numbered form, depending on the adjudicator's preference. Identify any facts that are dispositive for the issue(s) on appeal, and cite to the specific portions of the record to support the findings.

Example: *Separate findings of fact, numbered list*.

1. The appellant is seeking Medicare coverage for the inpatient hospital admission provided to the beneficiary from March 10, 2018, through March 11, 2018.

2. The beneficiary presented to the hospital for an elective, scheduled right heart catheterization with abdominal angiography.
3. The beneficiary's medical history included hypertension, peripheral vascular disease, and hyperlipidemia.

Example: *Separate findings of fact, narrative paragraph.* The appellant is seeking Medicare coverage for the inpatient hospital admission provided to the beneficiary from March 10, 2018, through March 11, 2018. The beneficiary presented to the hospital for an elective, scheduled right heart catheterization with abdominal angiography. (File 2, p. 4). The beneficiary's medical history included hypertension, peripheral vascular disease, and hyperlipidemia. *Id.*

Example: *Combined findings of fact and analysis.* The appellant is seeking reimbursement for home health skilled nursing and home health aide services provided to the beneficiary from July 30, 2019, through November 26, 2019. In order for home health services to qualify for Medicare coverage, according to section 1835(a)(2)(A) of the Act and 42 C.F.R. section 409.42, the beneficiary must be confined to the home, be under the care of a physician, require skilled services, and have an established plan of care. The 88-year-old beneficiary had diagnoses of Alzheimer's disease, chronic kidney disease, dementia, and unsteady gait. (File 1, p. 4). The beneficiary's assessments and physician-signed home health certifications and plans of care indicated she was homebound. (File 1, pp. 4–40, 163–196). Based on the record, the beneficiary was confined to the home, was under the care of a physician, and had an established plan of care, as required under 42 C.F.R. section 409.42 for coverage of home health services.

However, the record does not support that the beneficiary needed or received skilled services. The beneficiary's certifications and plans of care indicate that the physician ordered skilled nursing services for observation, assessment, instruction, and home health aide supervision. (File 1, pp. 4–5, 11–12). In order to qualify for Medicare coverage, skilled nursing services must consist of services that must be performed by a registered or practical nurse, must be provided on a part-time or intermittent basis, and must be reasonable and necessary for the treatment of the illness or injury. 42 C.F.R. § 409.44. The skilled nursing visits the beneficiary received consisted of the nurse observing and

instructing the beneficiary and supervising her home health aide. (File 1, pp. 41–58, 147–162). The beneficiary remained stable and did not have any significant changes in condition. *Id.* These services were custodial in nature and did not require performance by a registered or practical nurse. Therefore, the services were not skilled nursing services under 42 C.F.R. section 409.44 and do not satisfy Medicare coverage requirements. The beneficiary also received home health aide visits throughout the dates of service. (File 1, pp. 93–106, 197–217). Medicare coverage of home health aide services is dependent on the need for qualifying skilled services and coverage is not available for services furnished to a beneficiary who is not in need of qualifying services. 42 C.F.R. § 409.45. Therefore, because the skilled nursing services the beneficiary received were not qualifying services, the home health aide services the beneficiary received cannot be covered.

16.3.10 What is included in the conclusions of law section?

This section contains the conclusions that resulted from the analysis of how the relevant legal standards apply to the facts of the case.

Example: The home health services provided to the beneficiary from March 1, 2018, through March 14, 2018, do not meet Medicare coverage criteria under section 1835(a)(2)(A)(i) of the Act and 42 C.F.R. section 409.42 because the record does not support that the beneficiary was confined to the home. Pursuant to section 1879 of the Act, the provider is financially responsible for the non-covered costs.

Example: The hospice services provided by the appellant to the beneficiary from February 3, 2018, through February 20, 2018, do not meet Medicare coverage criteria under sections 1861(dd)(3)(A) and 1862(a)(1)(C) of the Act and 42 C.F.R. 418.20(b) because the beneficiary was not terminally ill with a life expectancy of six months or less. The appellant is financially responsible for the non-covered costs pursuant to section 1879 of the Act, and is not entitled to waiver of overpayment pursuant to section 1870 of the Act.

16.3.11 What is included in the order and signature section?

The order is the OMHA adjudicator's statement instructing the effectuating entity to act in accordance with the decision. The order is signed by the adjudicator.

Example: For the reasons discussed above, this decision is **UNFAVORABLE**. I direct the Medicare administrative contractor to process the claim in accordance with this decision.

Example: For the reasons discussed above, this decision is **FULLY FAVORABLE**. I direct the Part D plan sponsor to process the determination in accordance with this decision.

The signature line on the decision is not dated. The date on the Notice of Decision (OMHA-1051) or Notice of Decision Affirming Dismissal (OMHA-150), discussed in OCPM 16.5, is the date of the decision, and the date the disposition package is mailed.

Note: The following must all reflect the same date: the notice of decision, the decision letter mailed (DLM) date in the case processing system, and the date the disposition package is mailed (*see* OCPM 19.5.3).

Note: It is not necessary to discuss appeal rights in the decision. The accompanying notice of decision informs the recipients of the right to request review by the Council, if applicable.

16.3.12 What citation system must be used in OMHA decisions?

Use of the OMHA Citation Policy, available as a support material to this chapter, is mandatory and applicable to all written appeals correspondence generated by OMHA, including decisions, orders, and notices.

16.4 Other types of decisions

(Issued: 10-09-19, Effective: 10-09-19)

Most OMHA decisions follow a standard format (*see* OCPM 16.3.4) and use the general Decision template (OMHA-152). However, certain types of decisions may require a different format, such as:

- A decision affirming the dismissal of a request for reconsideration (*see* OCPM 16.4.1);
- A decision addressing multiple consolidated appeals (*see* OCPM 16.4.2); or
- A decision based on a stipulation made by CMS, a CMS contractor, or a plan (*see* OCPM 16.4.3).

16.4.1 When is a decision affirming dismissal issued, and what is the format?

When an appellant appealed a dismissal of a request for reconsideration, the OMHA adjudicator determines whether the dismissal was appropriate. If the adjudicator determines the dismissal of the request for reconsideration was correct, the adjudicator issues a Decision Affirming Dismissal (OMHA-151), accompanied by a Notice of Decision Affirming Dismissal (OMHA-150). The format of a decision affirming a dismissal is more abbreviated than a decision on a request for hearing, as the decision typically turns on a single procedural issue, and limited facts and analysis are required. This decision may not be appealed and is binding,[11] unless the adjudicator finds good cause to reopen the decision (*see* OCPM 16.6.2).

Note:	If an adjudicator finds that the dismissal of a request for reconsideration was incorrect, the adjudicator vacates the dismissal and remands the case (*see* OCPM 18.2.2).

[11] 42 C.F.R. §§ 405.1046(b), 423.2046(b).

16.4.2 When is a consolidated decision issued?

16.4.2.1 Can a decision be consolidated when an ALJ holds a consolidated hearing?

An ALJ may consolidate two or more appeals in one hearing on his or her own motion if the appeals involve one or more of the same issues, or for administrative efficiency.[12] If an ALJ holds a consolidated hearing, the ALJ may either:

- Combine the appeals in the case processing system and issue a consolidated decision; or
- Issue a separate decision and maintain a separate administrative record for each appeal.

If the ALJ issues a consolidated decision, the record must be consolidated and the appeals must be combined into a single OMHA appeal number (*see* OCPM 9.9.3). The disposition package for the consolidated decision is uploaded to the combined OMHA appeal number in the case processing system (*see* OCPM 19.4.3).

16.4.2.2 Can a decision be consolidated when an ALJ hearing is not held?

If a hearing is not held, an appellant may request to consolidate the decision and record for multiple appeals that are before the same adjudicator if the appeals involve one or more of the same issues.[13] It is within the discretion of the adjudicator to grant or deny the request for consolidation. If the request is granted, the appeals are combined under a single appeal number in the case processing system and a consolidated decision is issued addressing all of the claims or issues on appeal. An ALJ or attorney adjudicator may also consolidate the decision and record on his or her own motion.[14]

16.4.2.3 How is a consolidated decision organized?

A consolidated decision follows a similar format to the one described in OCPM 16.3.4. However, it may be more practical and efficient to vary from this format in consolidated decisions involving multiple claims. For example, a consolidated decision involving multiple claims for multiple beneficiaries might include combined procedural history and applicable law and policy sections, and separate findings of fact and analysis subsections for each beneficiary. Regardless of how the

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[12] 42 C.F.R. §§ 405.1044, 423.2044.
[13] 42 C.F.R. §§ 405.1044(b)(3), 423.2044(b)(3).
[14] *Id*.

consolidated decision is structured, each claim must be addressed in either a global or claim-specific analysis.

16.4.2.4 How are beneficiary PII and PHI protected?

In addition to the general protections of beneficiary PII and PHI discussed in OCPM 16.3.3, a multiple-beneficiary / multiple-claim list is created using Attachment A (OMHA-ATT) for cases with multiple beneficiaries/claims. The list contains truncated names and Medicare numbers for each beneficiary.

16.4.3 When is a stipulated decision issued?

A stipulated decision may be issued when CMS, a CMS contractor, or a plan[15] submits a written statement, or makes an oral statement at a hearing, indicating that an enrollee's at-risk determination should be reversed, or that the items or services at issue should be covered or payment may be made, and agreeing to the amount of payment that the parties believe should be made, if the amount of payment is at issue.[16]

Because stipulated decisions are fully favorable and agreed to by CMS, a CMS contractor, or a plan, it is not necessary for an adjudicator to issue a decision using the standard decision format. The Stipulated Decision (OMHA-155) consists of a single section for summarizing the procedural history that led to the stipulated decision, and omits the sections for making independent findings of fact and conclusions of law, or otherwise explaining the reasons for the decision.

16.4.4 When is a recommended decision issued?

An OMHA adjudicator only issues a recommended decision when directed to do so by the Council in a remand order. An OMHA adjudicator may not issue a recommended decision on his or her own motion.

16.4.5 When is a bench or oral decision issued?

Bench or oral decisions are not permitted. Regulations require that a decision must be written.[17]

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[15] Although 42 C.F.R. section 405.1038(c) applies only to CMS and CMS contractors, in the context of a Part C appeal, it is "appropriate" under 42 C.F.R. section 422.562(d) to read the regulation as also applying to MA plans. In Part D appeals, 42 C.F.R. section 423.2038(c) explicitly applies to statements made by a Part D plan sponsors.
[16] 42 C.F.R. §§ 405.1038(c), 423.2038(c).
[17] 42 C.F.R. §§ 405.1046(a), 423.2046(a).

Note:	While the outcome of a stipulated decision (*see* OCPM 16.4.3) may be clear at the time of the hearing, the decision must be written and does not have legal effect until the written decision is issued.

16.4.6 When is a proposed decision adopted?

An appellant or party may proffer a proposed decision to the OMHA adjudicator as a recommendation. A proposed decision is not a valid OMHA decision and may not be issued as submitted. If the adjudicator agrees with the reasoning and outcome of the proposed decision, the adjudicator must issue a new decision that uses the OMHA Decision template (OMHA-152) and is consistent with OMHA policies and procedural requirements.

16.5 Notices of decision

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A notice of decision must accompany each decision issued by an OMHA adjudicator. Using an OMHA-approved notice of decision template is mandatory in order to ensure all necessary information is included in every notice.[18] OMHA has approved templates for Notice of Decision (OMHA-1051), Notice of Amended Decision (OMHA-1051A), Notice of Decision Affirming Dismissal (OMHA-150), and Notice of Amended Decision Affirming Dismissal (OMHA-150A). The notice of decision must contain the date the decision is mailed, and is included in the disposition package that is sent to the parties and other recipients (*see* OCPM 19.5.2).

The notice of decision indicates that the decision is not precedential, does not release the appellant from civil or criminal liability, and that the decision may be reopened within 180 calendar days from the date of the decision for good cause, or at any time if it was procured by fraud or similar fault (*see* OCPM 20.6).

The OMHA-1051 and 1051A templates state that there is a right to request review of the decision by the Council within 60 calendar days of the date the notice is received, and provides appeal instructions. They also indicate that the Council may decide to review the decision on its own motion. The notices state that, if no party appeals to the Council and the Council does not review the decision on its own motion, the decision is binding on all parties and there is no right to request federal court review.

[18] *See* 42 C.F.R. §§ 405.1046, 423.2046.

16.6 Effect of the decision

(Issued: 10-09-19, Effective: 10-09-19)

16.6.1 Does OMHA effectuate the decision?

OMHA does not have a role in effectuating decisions. Other than the statement directing the contractor to process the decision, OMHA cannot direct any entity to take action or otherwise facilitate effectuating a decision. See OCPM 20.1 for further information on effectuating decisions.

16.6.2 Is an OMHA decision binding?

The decision of an OMHA adjudicator is binding on all parties after the disposition package is mailed to the required recipients in accordance with OCPM 19.5 and the case is closed in accordance with OCPM 19.1, *unless* one of the following occur:

- The OMHA adjudicator, or an Associate Chief ALJ if the original adjudicator is unavailable (*see* OCPM 20.6.2), **reopens** the decision;
- A party **appeals** the decision to the Council,[19] and:
  - The Council issues a decision modifying or reversing the OMHA adjudicator's decision;
  - The Council remands the case; or
  - The appellant escalates the case from the Council to Federal district court;
- CMS, a CMS contractor, or SSA refers the case to the Council for **own motion review**, and the Council accepts the referral and issues a decision modifying or reversing the OMHA adjudicator's decision, or remands the case;[20]
- The OMHA adjudicator's decision is a **recommended decision** directed to the Council, and the Council issues a decision;[21]
- A party requests **Expedited Access to Judicial Review (EAJR)** after an OMHA adjudicator issues a decision, the DAB's review entity certifies that the party meets the requirements for EAJR, and a Federal district court issues a decision or remand;[22] or

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19 42 C.F.R. §§ 405.1048(a)(1), 423.2048(a)(1).
20 42 C.F.R. §§ 405.1048(a)(1), 405.1110(a)–(b), 423.2048, 423.2110(a)–(b).
21 42 C.F.R. §§ 405.1048(a)(4), 423.2048.
22 42 C.F.R. §§ 405.1048(a)(3), 405.990, 423.2048(a)(3), 423.1990.

- In a case remanded by a Federal district court, the **Council assumes jurisdiction** and the Council issues a decision.[23]

16.6.3 May a decision be amended after it is issued?

A decision may be amended after it is issued to correct a clerical error, such as a typographical error, and must be amended if the error is preventing effectuation. An amended decision may be issued on the adjudicator's own motion or at the request of a party or effectuating entity, and a copy of the amended decision is sent with a Notice of Amended Decision (OMHA-1051A) or Notice of Amended Decision Affirming Dismissal (OMHA-150A) to the parties who were sent the initial notice of decision. See OCPM 20.5 for more information on issuing an amended decision.

16.6.4 Under what circumstances can a decision be reopened?

A decision may be reopened by the adjudicator, or an Associate Chief ALJ if the original adjudicator is unavailable, for good cause within 180 calendar days of the date that it was issued, or at any time for fraud or similar fault. See OCPM 20.6 for information on reopening a decision.

[23] 42 C.F.R. §§ 405.1048(a)(5), 405.1138, 423.2048(a)(5), 423.2138.