Welcome and Update ALJ Hearing Process

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

Forum Objectives

- Provide updates on status of operations at OMHA.
- Share information on OMHA's efforts to manage its workload and the growing number of pending appeals
- Provide updates on the status of Departmental initiatives to help OMHA manage its growing appeal rates
- Answer questions from the appellant community

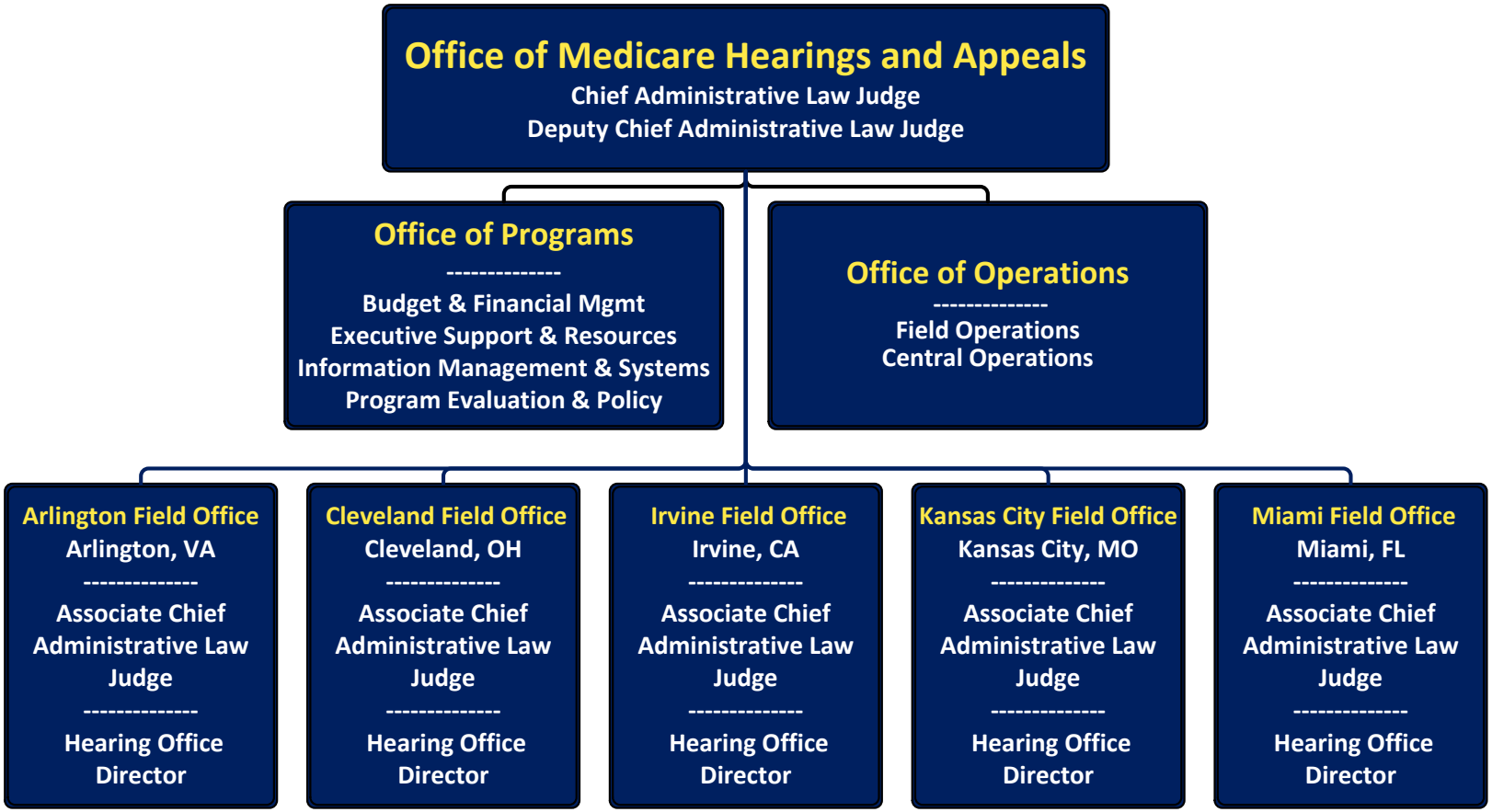
OMHA's Mission

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.

Appeals Process Parameters

- Impartial forum for adjudication
- Due process and opportunity to be heard
- Program integrity
- Public service role
- Effect of current workload and backlog on OMHA and its stakeholders
- Statutory 90 day goal for processing

OMHA Organization



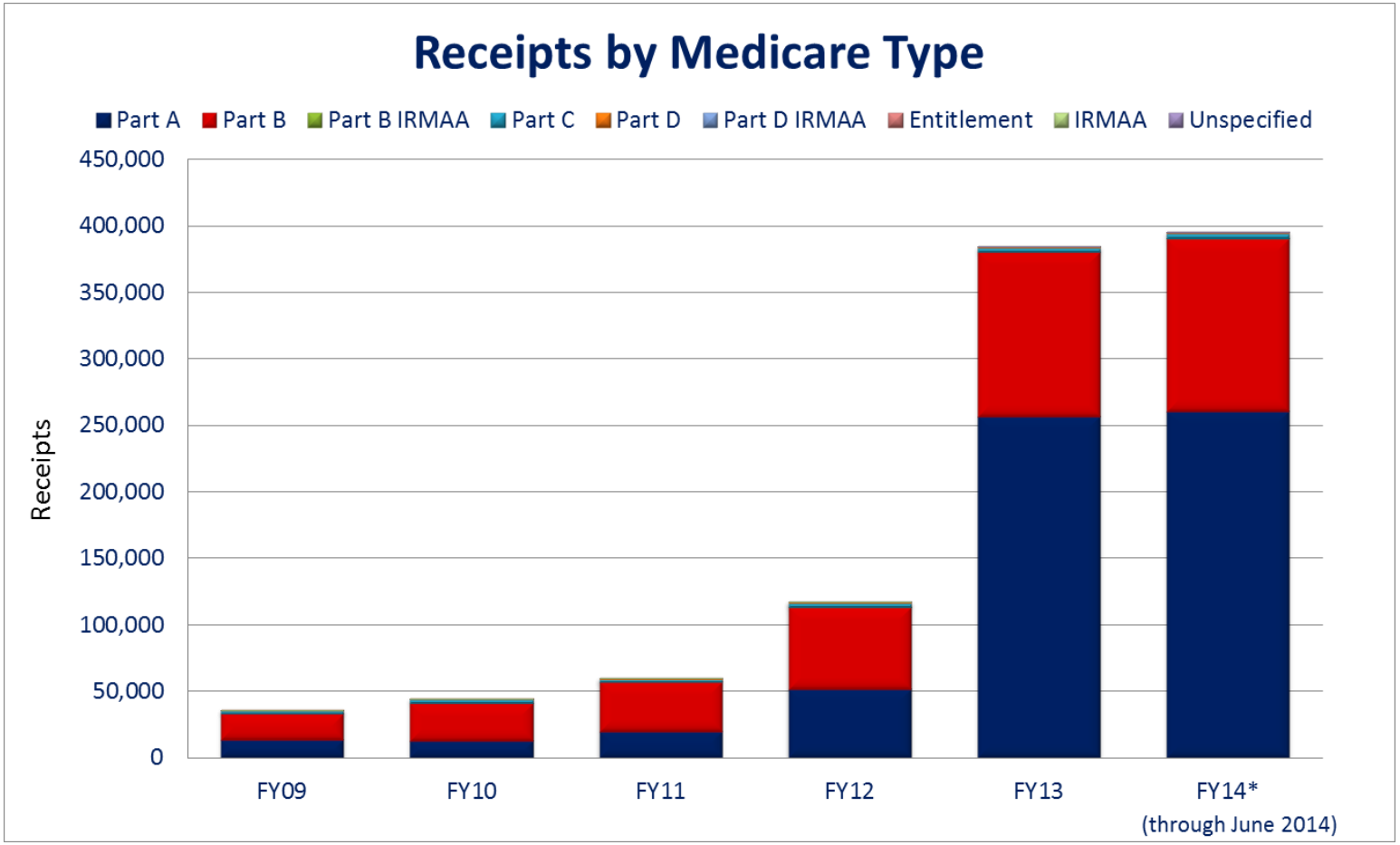
OMHA Workload

Types of Appeals

- Parts A and B pre- and post-payment claims (MACs, RACs, PSC/Z-PICs)
- Continuation of care (QIOs)
- Part C managed care coverage (Medicare Advantage Organizations)
- Part D prescription drug coverage (Prescription Drug Plans)
- Medicare eligibility and entitlement (SSA)
- Part B and D income-related premiums (SSA)

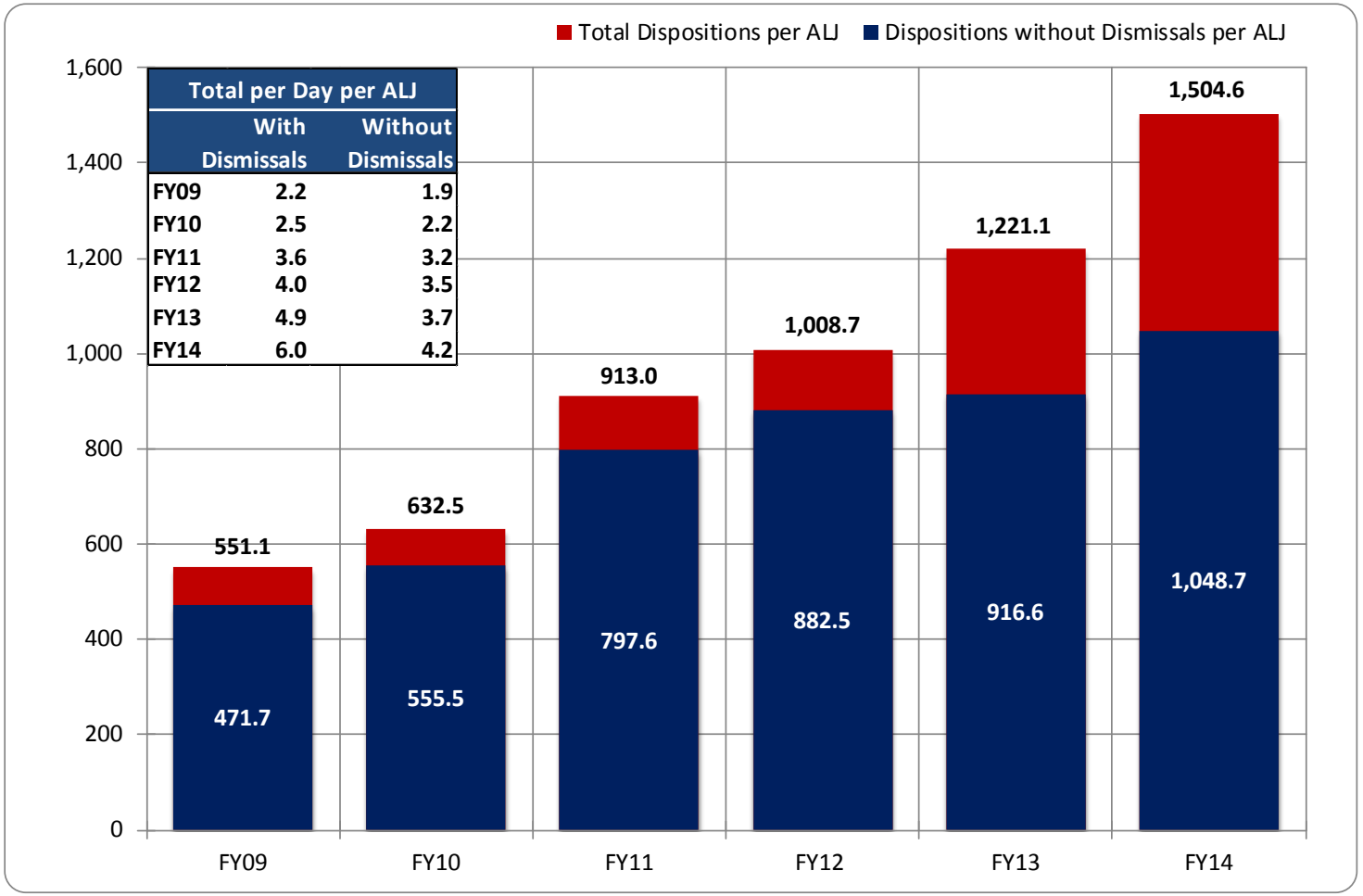
Receipt data corrected from original presentation

OMHA Workload – Receipts



*The FY14 receipts are based on estimated receipts through June 2014.
Includes appeals with RFH Date in listed year and does not include reopenings.
Run Date: November 13, 2014

OMHA Workload – ALJ Productivity

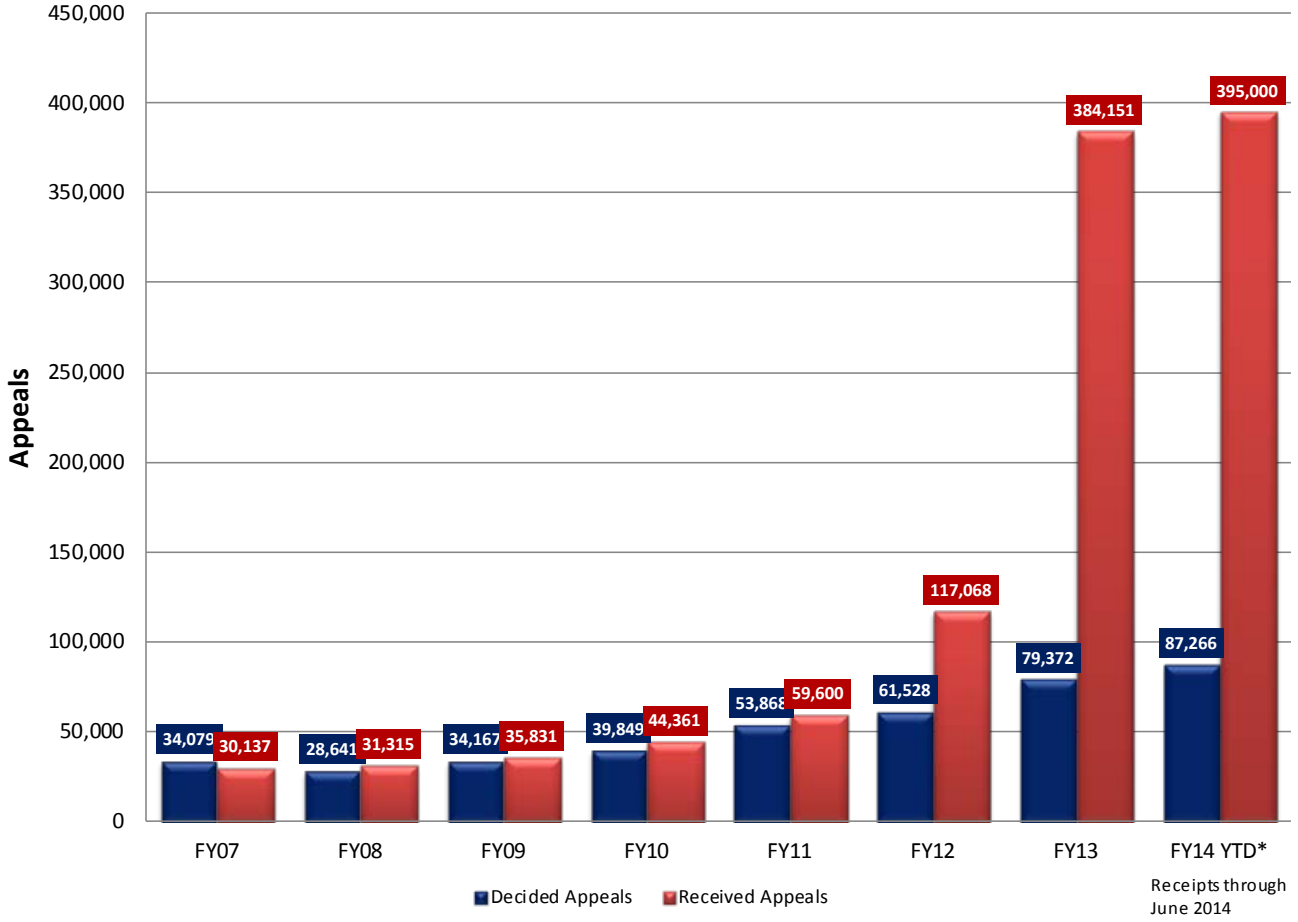


Total per Day per ALJ	With Dismissals	Without Dismissals
FY09	2.2	1.9
FY10	2.5	2.2
FY11	3.6	3.2
FY12	4.0	3.5
FY13	4.9	3.7
FY14	6.0	4.2

Appeals decided in listed fiscal year and excludes remands. FY14 dispositions are through September 2014.
Run Date: October 16, 2014

Receipt data corrected from original presentation

OMHA Workload – Received and Decided



*The FY14 receipts are based on estimated receipts through June 2014.

Received appeals represents cases with Request for Hearing Date in listed year.

Decided appeals represents cases decided in listed fiscal year no matter what year case was received.

Excludes Remands, Reopened and Combined Appeals.

Receipts may be incomplete due to data entry backlog.

FY14 Data as of September 30, 2014

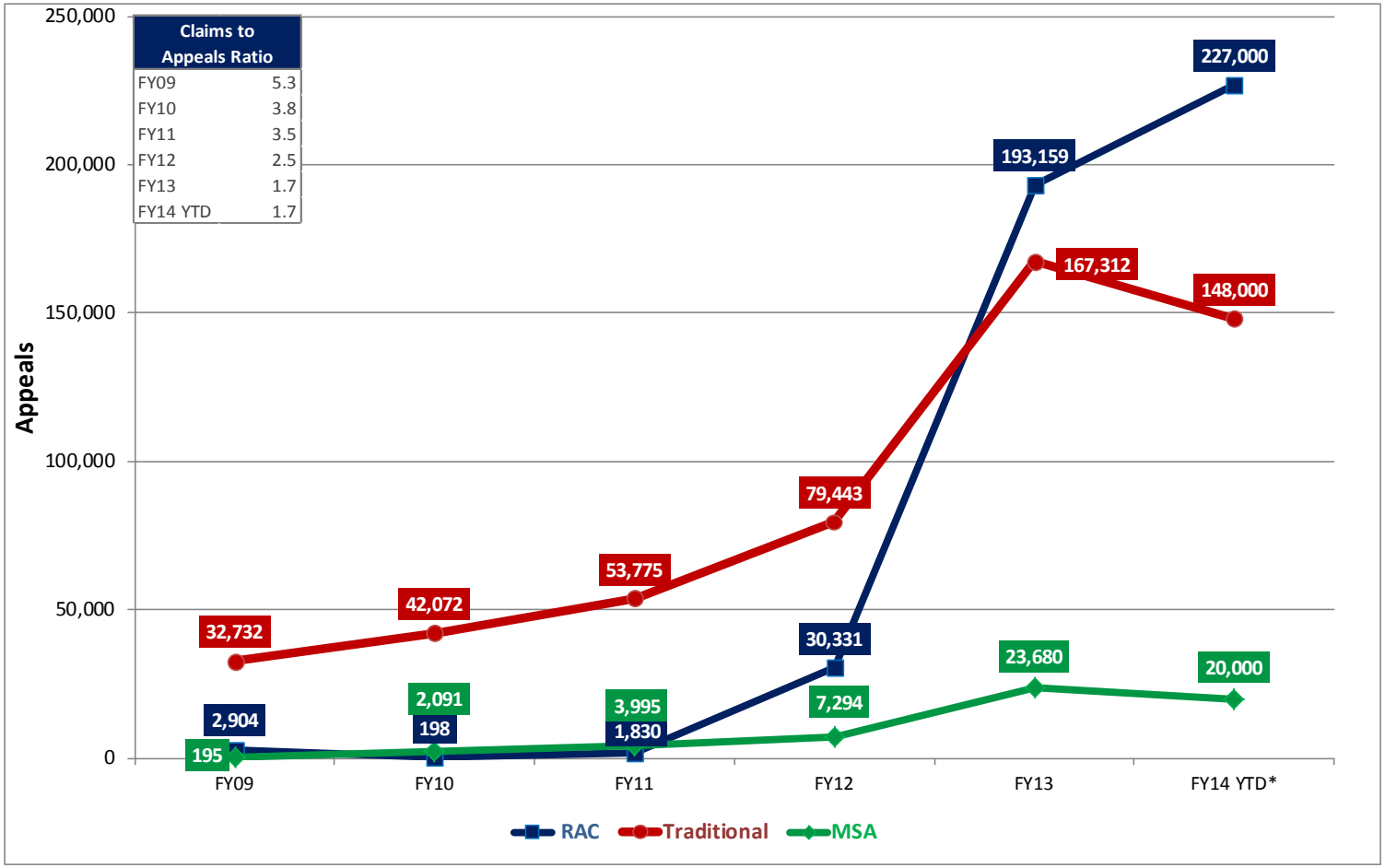
Run Date: November 13, 2014

OMHA Workload

- Reasons for increase in receipts
  - Cumulative effect of all post-payment audit programs
  - More active State Medicaid Agencies
  - Increase in base workload

Receipt data corrected from original presentation

Receipt Levels



*The FY14 numbers are based estimated receipts through June 2014.

Represents cases with Request for Hearing Date in listed year

Excludes reopened and combined appeals

FY14 receipts may be incomplete due to data entry backlog.

Run Date: November 13, 2014

OMHA Workload

- Workload versus Resources
  - FY14 budget - $82.381 million
  - 18.6% increase in appropriation over FY13 operational level ($69.444 million)
  - 14.4% increase over FY12 operational level ($72.011 million)
- FY 15 budget currently under a Continuing Resolution at FY 14 levels

OMHA Workload

- FY14 Initiatives
  - Adjudication Expansion
    - Kansas City Field Office Phase 1-7,000 additional dispositions per year
  - Augmented Adjudicatory Support Staff
    - 10 new staff members in Central Operations
  - Irvine Field Office Redesign Project
    - Greater space efficiencies – reduced square footage and reduced costs

Effect of Workload

- Due to the volume of receipts and substantial backlog, implemented deferred **ASSIGNMENT** process
  - Affects requests for hearing received in and after April of 2013
    - Requests for hearing held until an ALJ docket can accommodate
  - Assigned 34,121 deferred appeals (since February 3, 2014)
- Currently entering requests for hearing received in July 2014 into MAS (except bene requests).
- Currently assigning FY13 Q3 appeals
  - 59K appeals remaining from FY13Q3

Exceptions to Deferred Assignment

- Beneficiary-initiated appeals
  - 109.3 Days APT
  - 9,718 beneficiary appeals assigned (since July 15, 2013)
  - Number of decided since priority implemented, 7,879 as of September 30, 2014
- Expedited Part D Appeals still receive immediate attention

Effect of Workload – Avg Processing Time

Fiscal Year	Number of Days
FY09	**94.9**
FY10	**109.6**
FY11	**121.3**
FY12	**134.5**
FY13	**220.7**
FY14	**414.8**
October	301.3
November	325.8
December	343.7
January	371.0
February	383.3
March	402.4
April	418.7
May	441.4
June	463.2
July	488.7
August	495.5
September	514.5
FY14 Average	**414.8**

OMHA Initiatives

- Expansion of adjudication capacity
  - Kansas City Field Office

- Programmatic Initiatives
  - Standardizing our business process
  - Statistical sampling
  - Mediation

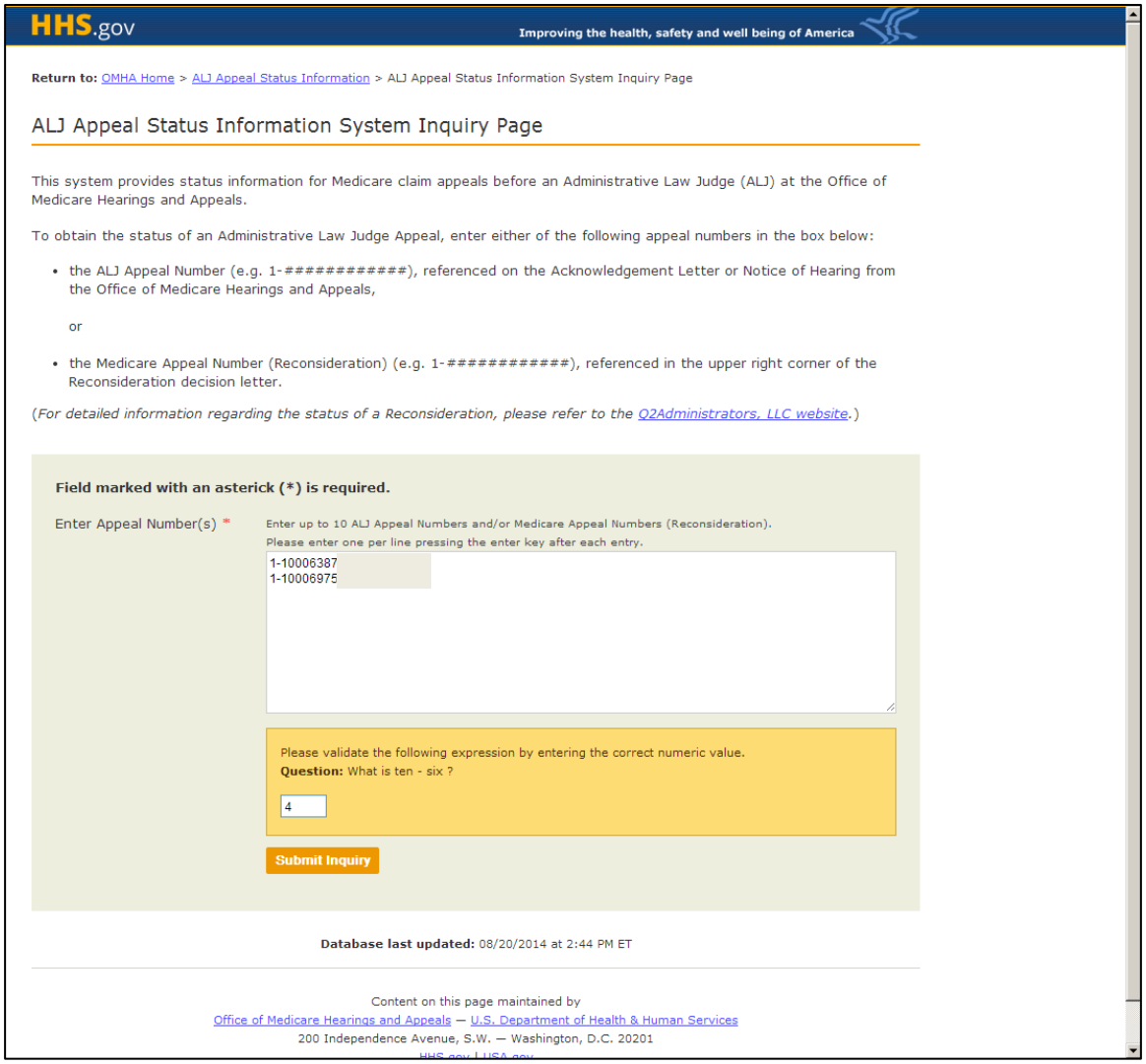
OMHA IT Initiatives

- ALJ Appeal Status Information System (AASIS) Website
- Electronic Case Adjudication and Processing Environment (ECAPE)
- Contract Scanning

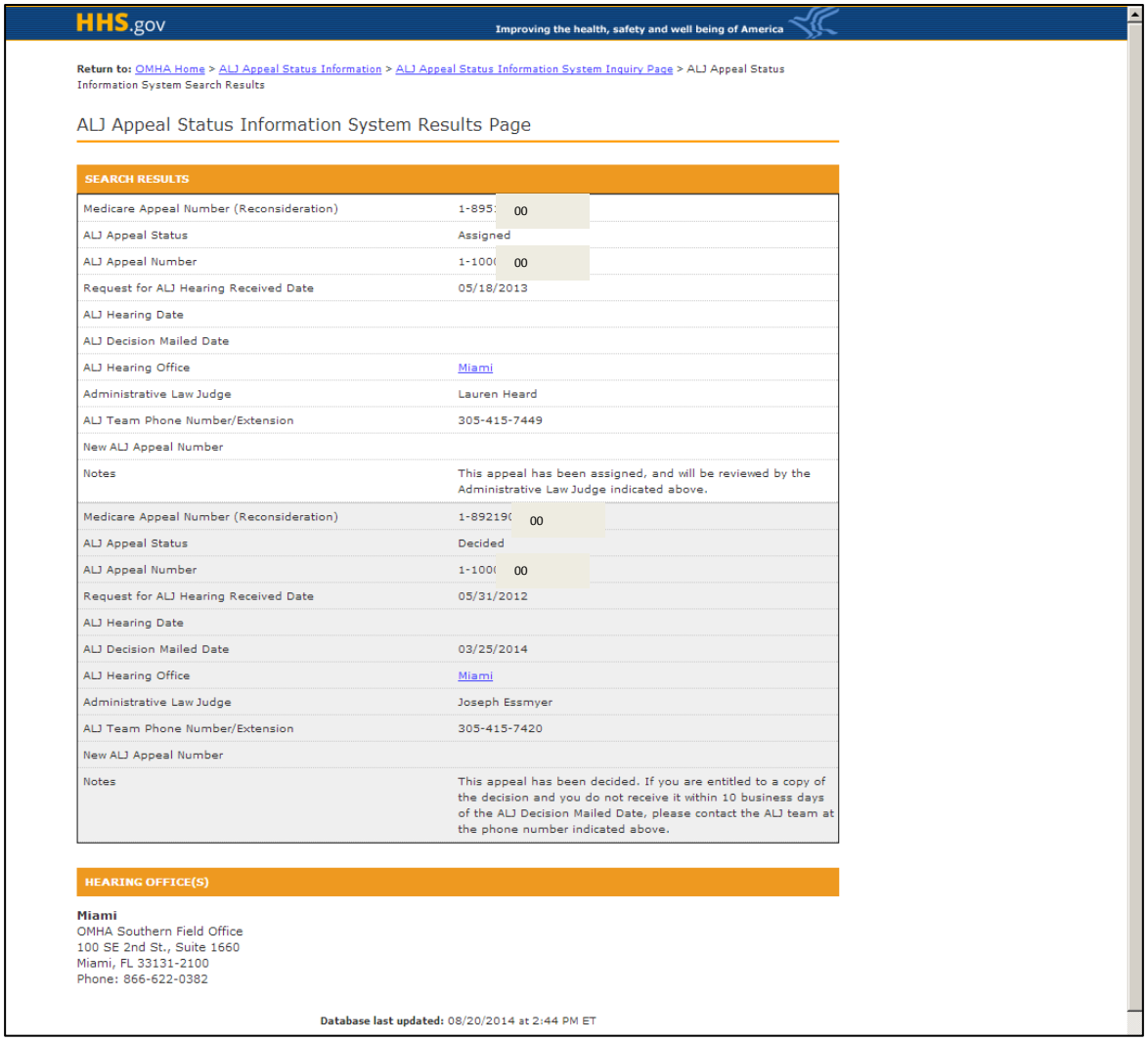
ALJ Appeal Status Information System (AASIS) Website

- Website that provides public access to appeal status information
- Allows users to query level 2 and/or level 3 appeal numbers and returns appeal data such as:
  - Date appeal received
  - Appeal status
  - Field office/ALJ assignment and team phone number
- Accessed through the OMHA website
- Implemented by the end of the calendar year

AASIS Website



AASIS Website



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Return to: OMHA Home > ALJ Appeal Status Information > ALJ Appeal Status Information System Inquiry Page > ALJ Appeal Status Information System Search Results

ALJ Appeal Status Information System Results Page

SEARCH RESULTS

Medicare Appeal Number (Reconsideration)	1-895[illegible]00
ALJ Appeal Status	Assigned
ALJ Appeal Number	1-100[illegible]00
Request for ALJ Hearing Received Date	05/18/2013
ALJ Hearing Date	
ALJ Decision Mailed Date	
ALJ Hearing Office	Miami
Administrative Law Judge	Lauren Heard
ALJ Team Phone Number/Extension	305-415-7449
New ALJ Appeal Number	
Notes	This appeal has been assigned, and will be reviewed by the Administrative Law Judge indicated above.
Medicare Appeal Number (Reconsideration)	1-89219[illegible]00
ALJ Appeal Status	Decided
ALJ Appeal Number	1-100[illegible]00
Request for ALJ Hearing Received Date	05/31/2012
ALJ Hearing Date	
ALJ Decision Mailed Date	03/25/2014
ALJ Hearing Office	Miami
Administrative Law Judge	Joseph Essmyer
ALJ Team Phone Number/Extension	305-415-7420
New ALJ Appeal Number	
Notes	This appeal has been decided. If you are entitled to a copy of the decision and you do not receive it within 10 business days of the ALJ Decision Mailed Date, please contact the ALJ team at the phone number indicated above.

HEARING OFFICE(S)

Miami
OMHA Southern Field Office
100 SE 2nd St., Suite 1660
Miami, FL 33131-2100
Phone: 866-622-0382

Database last updated: 08/20/2014 at 2:44 PM ET

Expected ECAPE Milestones

- Development Contract Award Date – January 2015
- Release I- Fall 2015 (October)
  - Case intake
  - Appellant Public Portal (Phase I)
    - Electronic filing of Request for Hearing
    - Submission of electronic evidence
- Release II-Spring 2016 (May)
  - The appeal adjudication process from ALJ assignment to closure
- Release III - Fall 2016 (November)
  - Enhanced Appellant Public Portal (Phase II)
    - Allows authenticated parties to view files electronically
    - Communication to and from OMHA

Contract Scanning Initiative

- Scan all unassigned Request for Hearings and associated documents
  - Transition to ECAPE
- Expected Implementation- December 2014

How Appellants will be Affected

- Case processing efficiencies
- Accessibility through the Portal will allow:
  - Electronic filing of Request for Hearing
  - Submission of electronic evidence
  - Authorized parties to view their file electronically
  - Communication to and from OMHA

What You Can Do to Help Reduce Processing Times

- Comply with the requirements for a request for hearing
  - Ensure you are filing a complete request
  - Send a copy of the request to all of the other parties
- Utilize the beneficiary mailstop if appropriate
- Do not submit duplicate requests for hearing

Reducing Processing Time

- If filing late, submit a request for an extension of time to request a hearing with the request
- Submit additional information *after* assignment to an ALJ
- Do not submit copies of documentation already submitted at a prior level
- More tips can be found on our website at **http://www.hhs.gov/omha/tips_for_filing_requests_for_hearing.pdf**

HOLD THAT THOUGHT—

QUESTIONS COME LATER

OMHA Initiatives

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

Settlement Conference Facilitation

- Pilot alternative dispute resolution process
- Part B items / services
- Providers / suppliers
- OMHA role is to facilitate
- Party and CMS roles are to discuss resolution
- Ends in an agreement if both agree

Settlement Conference Facilitation

- Pilot criteria on OMHA website:

  www.hhs.gov/omha/settlement_conference_facilitation_pilot.html

  - Part B QIC reconsideration
  - Appellant must be provider or supplier = NPI
  - No beneficiary liability / participation at QIC level
  - Jurisdiction for ALJ hearing (timely request, AIC met)
  - Filed in 2013 and not assigned to an ALJ
  - Each claim or extrapolated sample < $100,000
  - 20 claims at issue or $10,000 in controversy
  - Cannot also have pending request for OMHA sampling
  - Request must include all of the appellant's pending claims for the same item or service that meet SCF criteria
  - Request must include information on spreadsheet

Settlement Conference Facilitation

	A	B	C	D	E	F	G	H	I
1	**General Information** This spreadsheet requests the data needed by the Centers for Medicare & Medicaid Services to evaluate your claims for settlement conference. Electronic submission of the SCF Spreadsheet via CD is required; however, submitting your entire request package via CD is strongly encouraged. The spreadsheet must be submitted as a Microsoft Excel spreadsheet (please do **not** submit a PDF document of the information requested in this spreadsheet). **NOTE: One spreadsheet per CMS Certification Number (CCN) or Provider Transaction Number (PTAN) (see box 5 below). If your claims were billed under multiple CCNs or PTANs, you must complete separate spreadsheets identifying the SCF request claims billed per CCN or PTAN. The second tab at the bottom of this document contains the Spreadsheet Key.**								
2	Provider or Supplier Name:								
3	Type of Entity:								
4	National Provider Identifier (NPI):								
5	CCN or PTAN *(One CCN or PTAN per spreadshet, only)*:								
6	QIC Appeal Number	ALJ Appeal Number (if known)	Truncated HICN (last two numbers and the alpha-numeric suffix, only; one HICN per line)	# of Line Items Denied	Payer Claim Control Number	Billed Amount Denied	Claim Adjustment Reason Code (CARC)	MIA/MIAO or RARC (if any)	
7									
8									

Settlement Conference Facilitation

- Request processed by SCF team
- Procedural review for jurisdiction and SCF criteria
  - May communicate that SCF criteria not met or sufficient information not provided
  - If jurisdictional issue, may proceed to dismissal of RFH
- Confirmation of SCF request to appellant and CMS
- Scheduling call with appellant and CMS & SCF notice
  - Response to notice
- SCF session
  - Agreement = signed at session, appeals are dismissed
  - No agreement = appeals pick up where they were

OMHA Statistical Sampling

- Pilot sampling and extrapolation process
- Part A or B items / services
- Providers / suppliers
- OMHA-furnished statistician
- Medicare sampling methodology used (MPIM)
- ALJ decides sample claims

OMHA Statistical Sampling

- Pilot criteria on OMHA website:

  www.hhs.gov/omha/statistical_sampling_initiative.html

  - Part A or B QIC reconsideration
  - Appellant must be provider or supplier = NPI
  - No beneficiary liability / participation at QIC level
  - Jurisdiction for ALJ hearing (timely request, AIC met)
  - Currently assigned to an ALJ or filed 4/1/13 to 6/30/13
  - No hearing on claims scheduled yet
  - Minimum 250 claims in 1 of 3 categories:
    - Pre-pay, Post-pay non-RA, Post-pay RA
  - Cannot also have pending request for SCF
  - Request must include information on spreadsheet

OMHA Statistical Sampling

	A	B	C	D	E	F	G
2	Request for Statistical Sampling						
3	Claims Information Spreadsheet						
4							
5	This spreadsheet includes the information required for appealed claims for which an appellant is requesting statistical sampling. Electronic submission via CD of this Claim Information Spreadsheet (or other list with the same information that is compatible with Microsoft Excel) is mandatory.						
6							
7	Appellant Name:						
8							
9					Request for Hearing	Overpayment RAC	Overpayment non-RAC
10	NPI	QIC Number	ALJ Number, if known	Assigned ALJ, if known	Approximate Filing Date	Claim? [y/n]	Claim? [y/n]
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							

OMHA Statistical Sampling

- Stat Sampling coordinator processes appellant request *OR* makes offer from OMHA to an appellant
- Procedural review for jurisdiction and stat sampling criteria
  - May communicate that criteria not met or sufficient information not provided
  - If jurisdictional issue, may proceed to dismissal of RFH
- Pre-hearing conference conducted by an ALJ
  - Conference order issued — if no objection, becomes binding
- Combined appeal assigned to ALJ for hearing
- Hearing on sample units
  - Can you discuss the sample methodology — YES!
  - Can you question the OMHA statistician — YES!
  - Can you bring your own statistical expert — YES!
- Extrapolation and effectuation by CMS

OMHA Initiatives

- Beginning 6 month evaluation for SCF and Stat Sampling pilots
  - If any changes, expect them in January
- Continuing to explore other potential initiatives

OMHA Initiatives

- Please visit the OMHA website for updates and more information
- Please follow the instructions

www.hhs.gov/omha

Settlement Conference Facilitation—
OMHA.SCF@hhs.gov

OMHA Statistical Sampling —
OMHA.stat.sampling@hhs.gov

Provider Relations Coordinator

Date of Delivery for DME

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

Role and Responsibilities

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

Proof of Delivery

- Benefit Integrity (BI) and Medical Review (MR) requirement for certain items of DME
- Dual Purpose
  - BI – Supplier protection the item was delivered
  - MR - Confirm what was ordered is correctly coded and the date of the service is correct on the claim
- "Upon delivery of an item, the beneficiary or their designee is required to review the delivery ticket and must provide a signature which signifies knowledge, approval, and delivery of the item."

Proof of Delivery - Problem

- Stakeholders complained contractors were denying because the delivery date was not personally filled in by the beneficiary

- CMS guidance in Program Integrity Manual Ch.4 Section 4.26.1
  - The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee…
  - The instructions were silent as to who may enter the date of delivery

- Contractors acknowledge common practice to auto-fill this section

Proof of Delivery - Solution

- CMS Issues Clarification to Contractors

  - April 10 – Instructions to DME MACs to accept pre-dated/autofills of beneficiary/designee dates on delivery tickets and to reinforce the date must be the date received=Date of Service

  - August 8th – DME MACs issued a joint Educational Article on Requirements

Published Educational Article – Requirements for Signature Date

- Autofilling the date of delivery on delivery documentation or Proof of Delivery is a common business practice for many DMEPOS suppliers. Upon delivery, the Medicare beneficiary or designee is required to review the POD and must provide his or her signature….
- Based on instructions, the POD delivery date element is not required to be personally filled in by the beneficiary/designee. The date of delivery maybe entered by the beneficiary, designee or the supplier. The date entered must be the actual date of service.

Increasing Access to Lower Level Appeals Adjudicators

Arrah Tabe-Bedward
Director
Medicare Enrollment and Appeals Group

Feedback from the February Appellants Forum

Appellants need an opportunity to dialogue with adjudicators before the ALJ level of appeal.

Proposed Change

Modify one of the lower appeals levels to include an opportunity for communication between appellants and adjudicators.

General Framework

- Insert at the lower appeals levels
- Allow appellants and adjudicators to ask questions and supplement the case file
- Include an opportunity for adjudicators to consider the additional information received through this process prior to issuing their decision
- Initially limit to one contractor
- Initially include a small subset of claims types
- Voluntary participation

Goals

- Increase the number of appeals that are resolved at the lower levels/before the ALJ level
- Improve the quality of future claims filings
- Improve the quality of future appeals filings

Tentative Timeline

- Considering multiple implementation vehicles
- Will depend on the vehicle that we use
- Expect to have a decision within the next few months

Departmental Appeals Board Update
MEDICARE APPEALS COUNCIL

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

DEPARTMENTAL APPEALS BOARD (DAB)

The DAB is a 76-person umbrella organization, located within the Office of the Secretary and comprised of:

- Departmental Appeals Board Members
- Civil Remedies Division Administrative Law Judges
- Medicare Appeals Council
- Alternative Dispute Resolution Division

MEDICARE APPEALS COUNCIL

The Medicare Appeals Council (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:

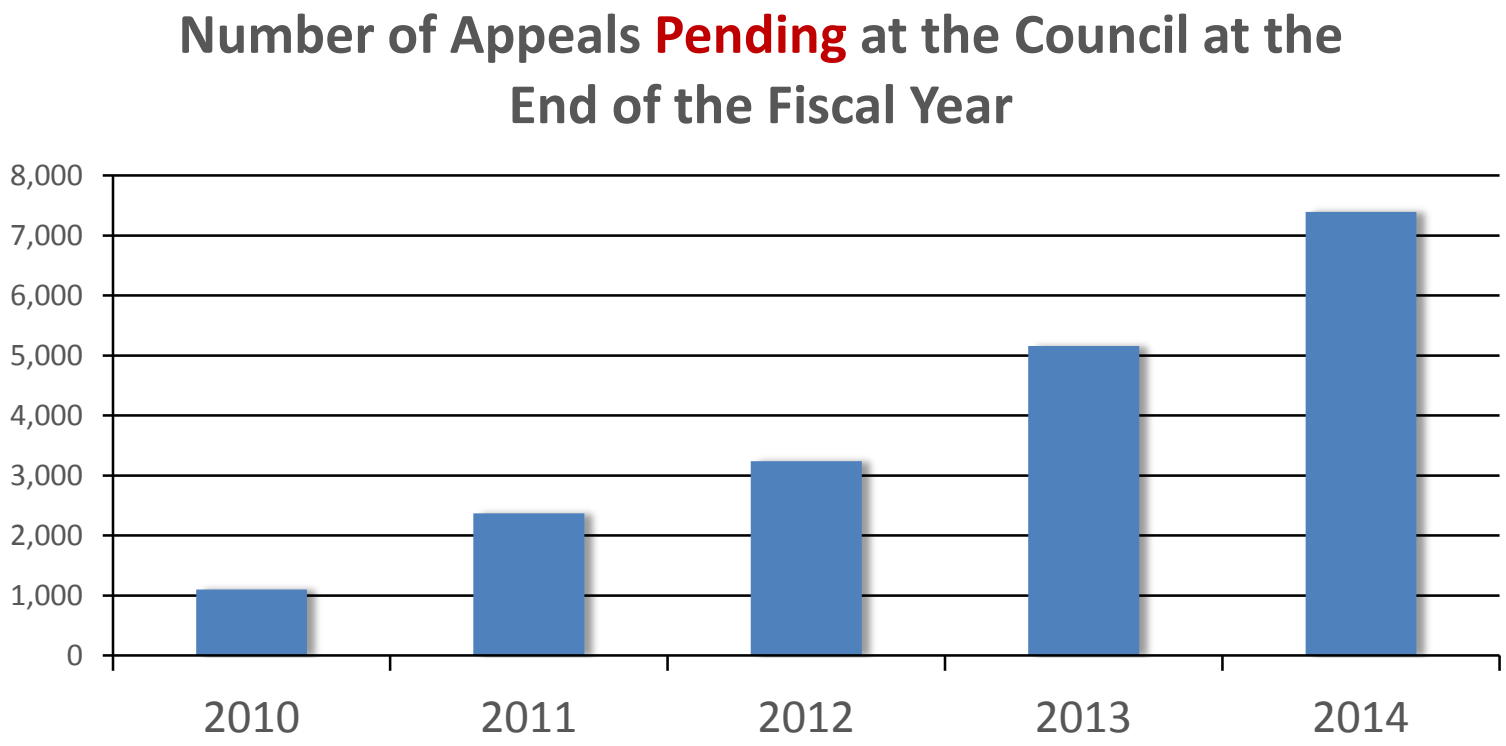
- -Adopt
- -Reverse
- -Modify
- -Dismiss
- -Remand

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

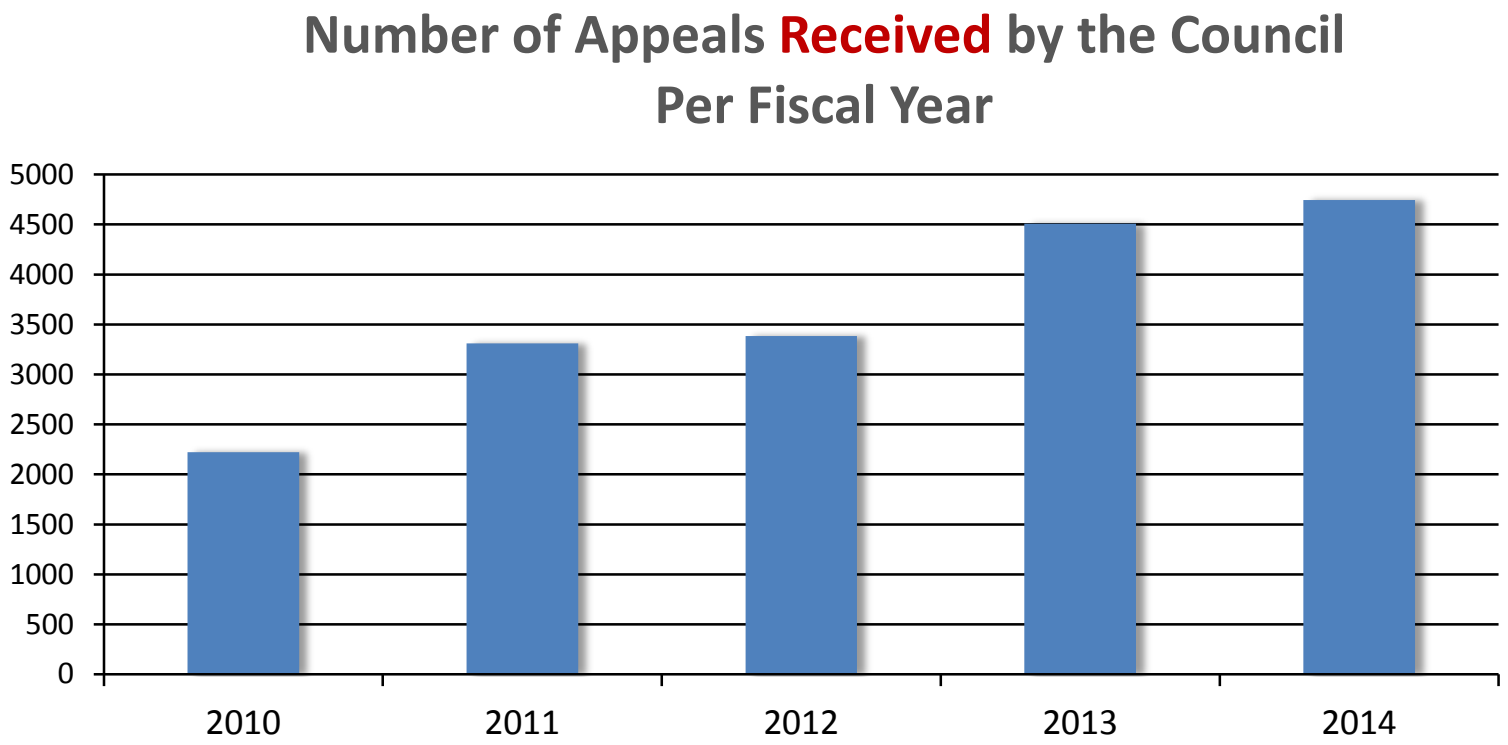
Status of Appeals at the DAB

- The number of requests for Council review is steadily increasing.
- In FY 2014, the Council closed 2,513 appeals (9,836 individual beneficiary claims).
- At the end of FY 2014, the number of pending appeals was approximately 7,394. This is **43% more appeals pending than at the end of FY 2013**, when there were approximately 5,158 appeals pending.

Appeals Pending at the Council

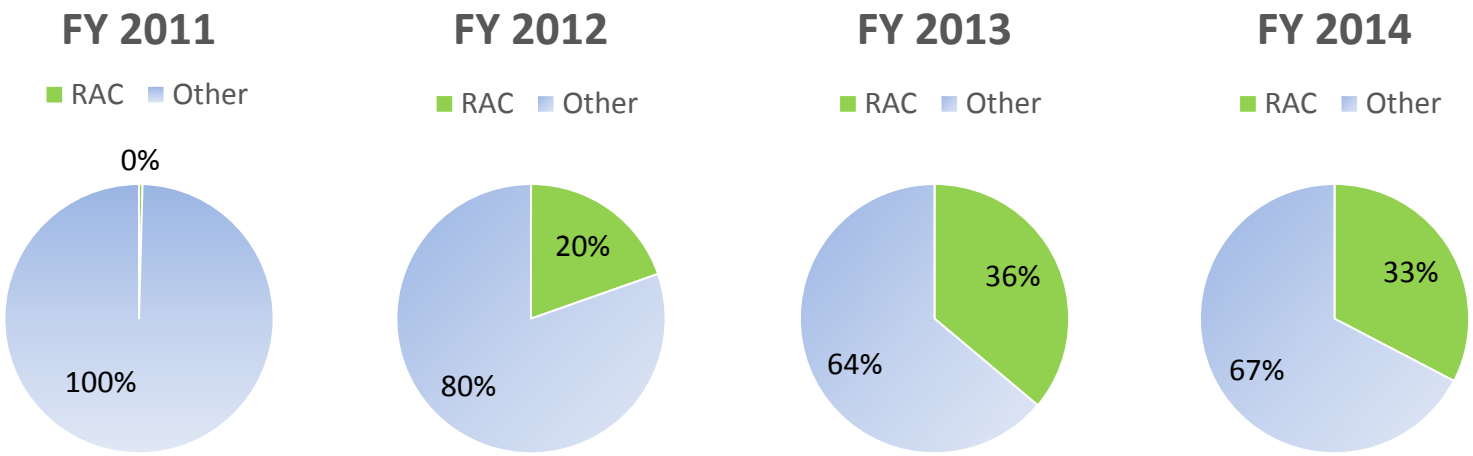


Appeals Received by the Council



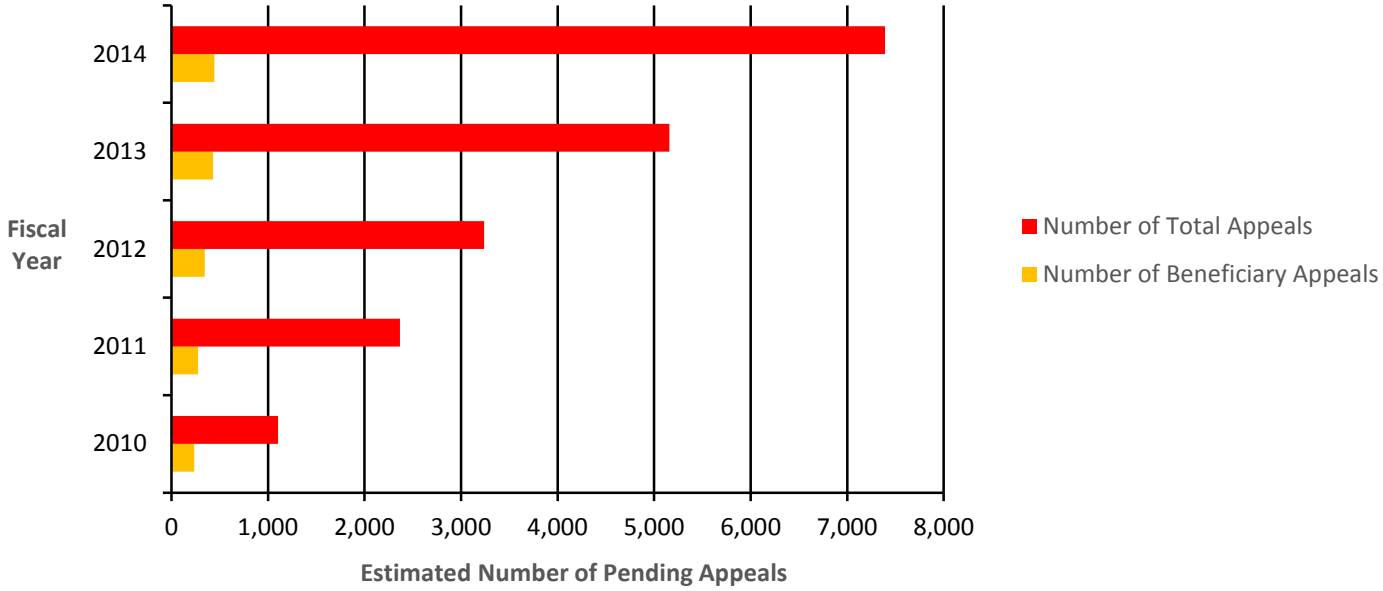
Increase in the DAB Caseload

- Increase in OMHA's case receipts and disposition rates
- Increase in overpayment (including Recovery Audit Contractor) and statistical sampling appeals

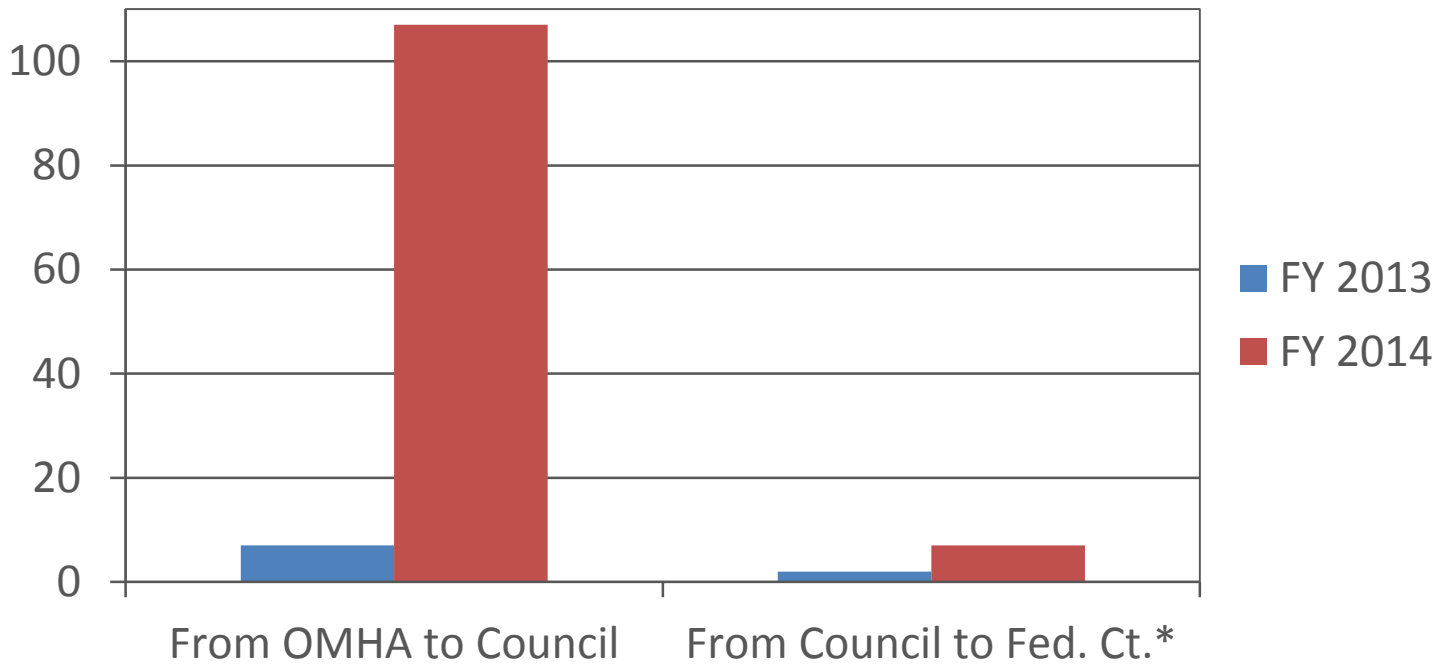


Beneficiary-Focus

- The Council is unlikely to meet the 90-day timeframe for issuing decisions in most appeals
- The Council will give priority to beneficiary appeals (including Part C)



ESCALATIONS



*The Council has issued decisions in all appeals for which escalation to federal district court has been requested

Escalations from OMHA to the Council

- The Council will:
  - NOT hold a hearing or conduct oral argument unless there is an extraordinary question of law/policy/fact
  - Only consider new evidence if the appellant has good cause for submitting it for the first time to the Council
  - Review the QIC's decision *de novo*
  - Start the 180 day timeline beginning on the date the request for escalation is perfected by the appellant
  - Issue a decision, dismissal, or remand to the ALJ for further proceedings

Escalations from the Council to Federal Court

- If the Council has not issued a decision within 90 days from the date it received an appellant's request for review, the appellant may file a request for escalation to federal court in writing to the Council
- After receiving a request for escalation, within 5 calendar days, the Council must:
  - Issue a decision;
  - Issue a dismissal;
  - Remand the case to the ALJ; OR
  - Send notice to the appellant acknowledging receipt of the request to escalate and confirming that it is unable to issue a decision

42 C.F.R. § 405.1132

Managing the Increasing Caseload: Council's Actions

- Electronic records
- Appeal consolidation

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

Appeals Consolidation

- Appeals filed by a single appellant with identical issues of law and no significant factual dispute are being consolidated
- The Council issues one decision in consolidated appeals which allows the affected appeals to be processed more quickly

PRACTICE TIP:

Follow the instructions in the Council's Acknowledgement Letter

When filing a request for review:

- **CONTENTIONS**: Include an explanation of what part(s) of the ALJ action you disagree with and your reason(s)
- **COPY THE OTHER PARTIES**: Send a copy of the request for review to each party copied by the ALJ. It is not enough to simply send the other parties a letter stating that you have filed an appeal.
- **NEW EVIDENCE**: Notify the other parties of what, if any, supplemental material or new evidence was submitted with the request for review and make it available if requested. Unless instructed otherwise, the Council does not require that you send such documents to each party.

Thank you for your attention.