Office of Medicare Hearings and Appeals

Medicare Appellant Forum

Wednesday, February 12, 2014

Welcome

Please stand-by --the Forum will begin promptly at 10:00 a.m.

Please
Be in your seats at start time
Mute your phone or place in vibrate mode
Do not bring any food or drinks into the auditorium

Administrative Comments

Segundo Pereira
Director of Operations
Office of Medicare Hearings and Appeals

Administrative Comments

- General Announcements:
  - Forum materials – Available On-Line
  - Feedback Critique – On-Line
- Webinar Participants
  - Close Captioning
  - Dial In/Out Procedures
  - WEBEX Use
- Auditorium Audience:
  - Security – Badges and Limitations
  - Emergency Procedures – Assembly Area
  - Restrooms
  - Coat Room & Luggage Storage
  - Cafeteria – Basement Level
  - Weather Advisories
  - Question & Answer Session

Agenda

Wednesday, February 12, 2014

8:30 a.m. - 10:00 a.m.	**Check-In/Breakfast at Leisure**
10:00 a.m. - 10:10 a.m.	**Administrative Comments**
10:10 a.m. - 11:00 a.m.	**Update on Level III Medicare Appeals Workload**
11:00 p.m.. - 11:30 p.m..	**Policy Update**
11:30 a.m. - 12:00 p.m..	**IT Initiatives Impacting the Appeals Process—what they are, and what they mean to you**
12:00 p.m. - 12:45 p.m.	**The Request for ALJ Hearing—Level III**
12:45 p.m.. - 1:45 p.m..	**Lunch at Leisure**

Agenda

Wednesday, February 12, 2014

1:45 p.m.. - 2:30 p.m.	**The Administrative Hearing – "Appellant Do's and Don'ts"**
2:30 p.m.. - 3:00 p.m.	**Medicare Appeal Levels I & II – Overview & Update - CMS**
3:00 p.m.. - 3:30 p.m.	**Departmental Appeals Board Update - Medicare Appeals Council**
3:30 p.m.. - 3:45 p.m.	**Break**
3:45 p.m.. - 4:45 p.m.	**Medicare Appeals – Levels I through IV – Q&A Forum**
4:45 p.m.. - 5:00 p.m.	**Closing Remarks**

Welcome and Update
ALJ Hearing Process

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

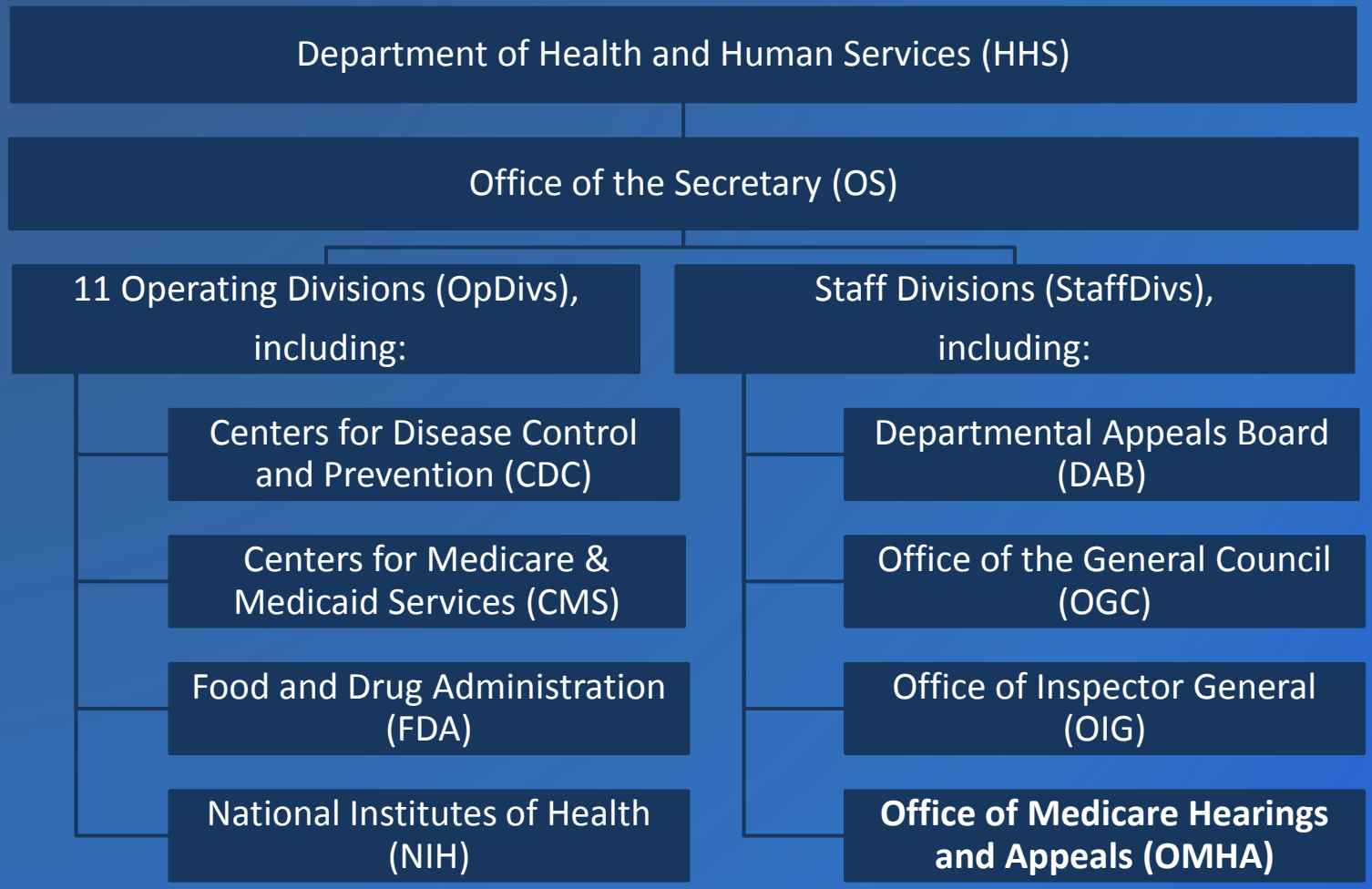
Forum Objectives

- Provide updates on the status of OMHA operations
- Provide information on OMHA's initiatives to help mitigate the growing backlog
- Provide information on what appellants can do to make the process more efficient
- Answer questions from the appellant community

Presentation Overview

- Background
  - OMHA's place within the Department
  - Organizational overview
  - Mission statement
- Current workload and backlog, and the effect on OMHA and appellants
- OMHA workload/backlog initiatives
- Steps appellants can take to help us reduce processing time

OMHA's Place within the Department



OMHA Organization

Office of Medicare Hearings and Appeals
Chief Administrative Law Judge
Deputy Chief Administrative Law Judge

Office of Operations

Field Operations
Central Operations

Office of Programs

Budget & Financial Mgmt
Executive Support & Resources
Information Mgmt & Systems
Program Evaluation & Policy

Mid-Atlantic Field Office
Arlington, VA
Associate Chief Administrative Law Judge
Hearing Office Director

Midwestern Field Office
Cleveland, OH
Associate Chief Administrative Law Judge
Hearing Office Director

Southern Field Office
Miami, FL
Associate Chief Administrative Law Judge
Hearing Office Director

Western Field Office
Irvine, CA
Associate Chief Administrative Law Judge
Hearing Office Director

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.

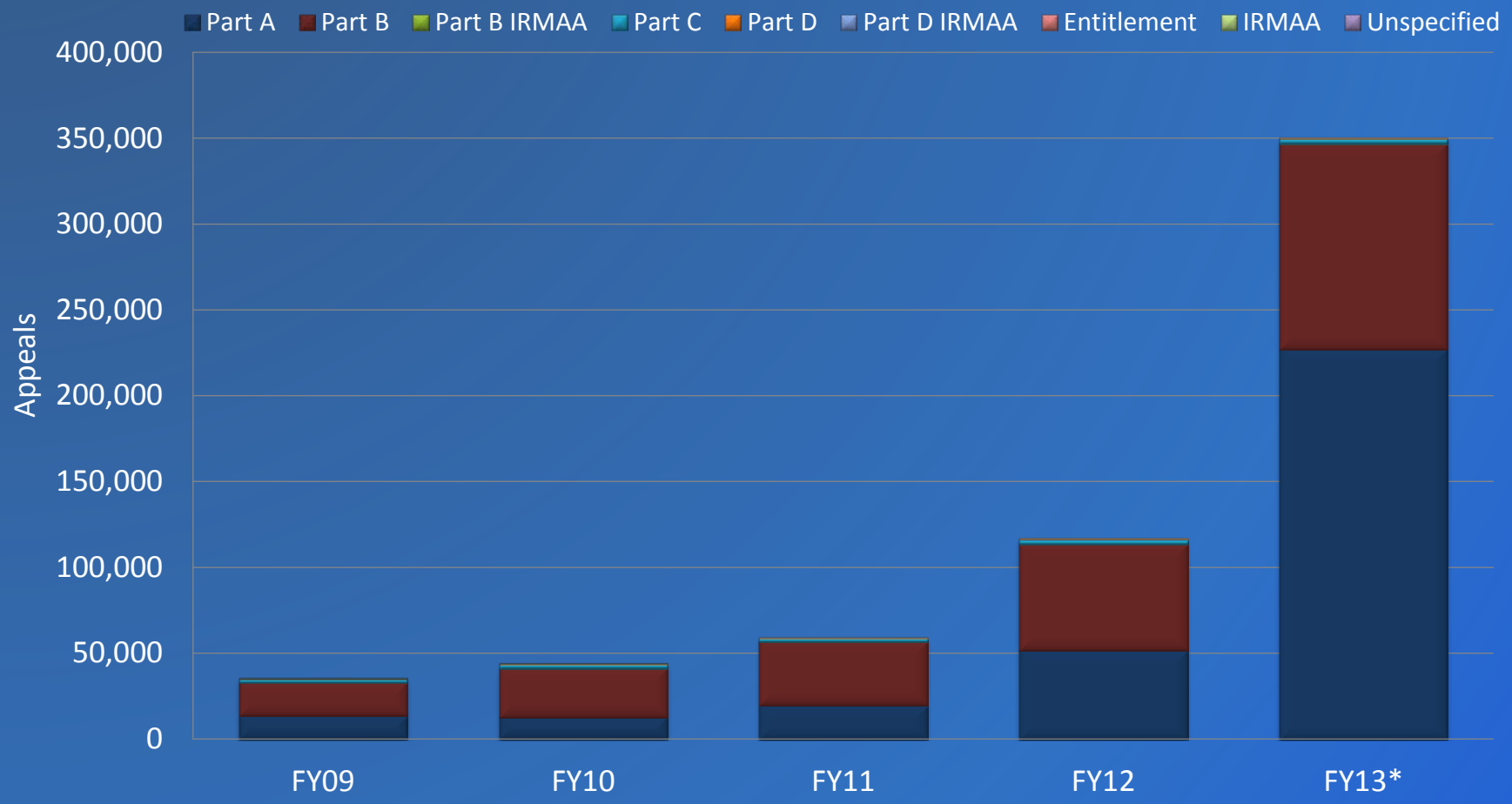
OMHA Workload

Types of Appeals

- Medicare eligibility and entitlement (SSA)
- Part B and D income-related premiums (SSA)
- 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)

OMHA Workload

Receipts by Medicare Type

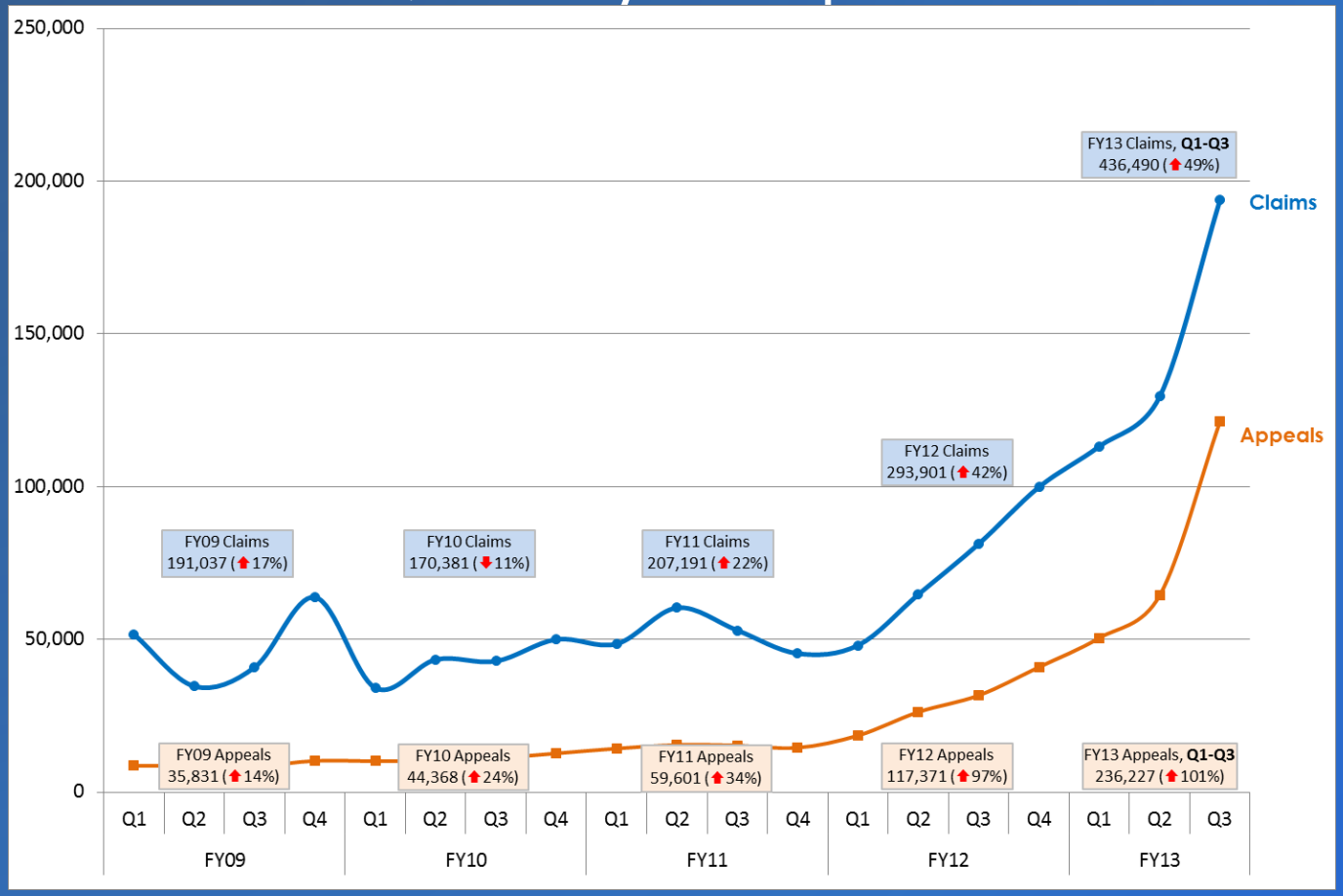


*Includes appeals with RFH Date in listed year and does not include reopenings. FY13 receipts are estimated.

Run Date: January 24, 2014

OMHA Workload

Quarterly Receipts

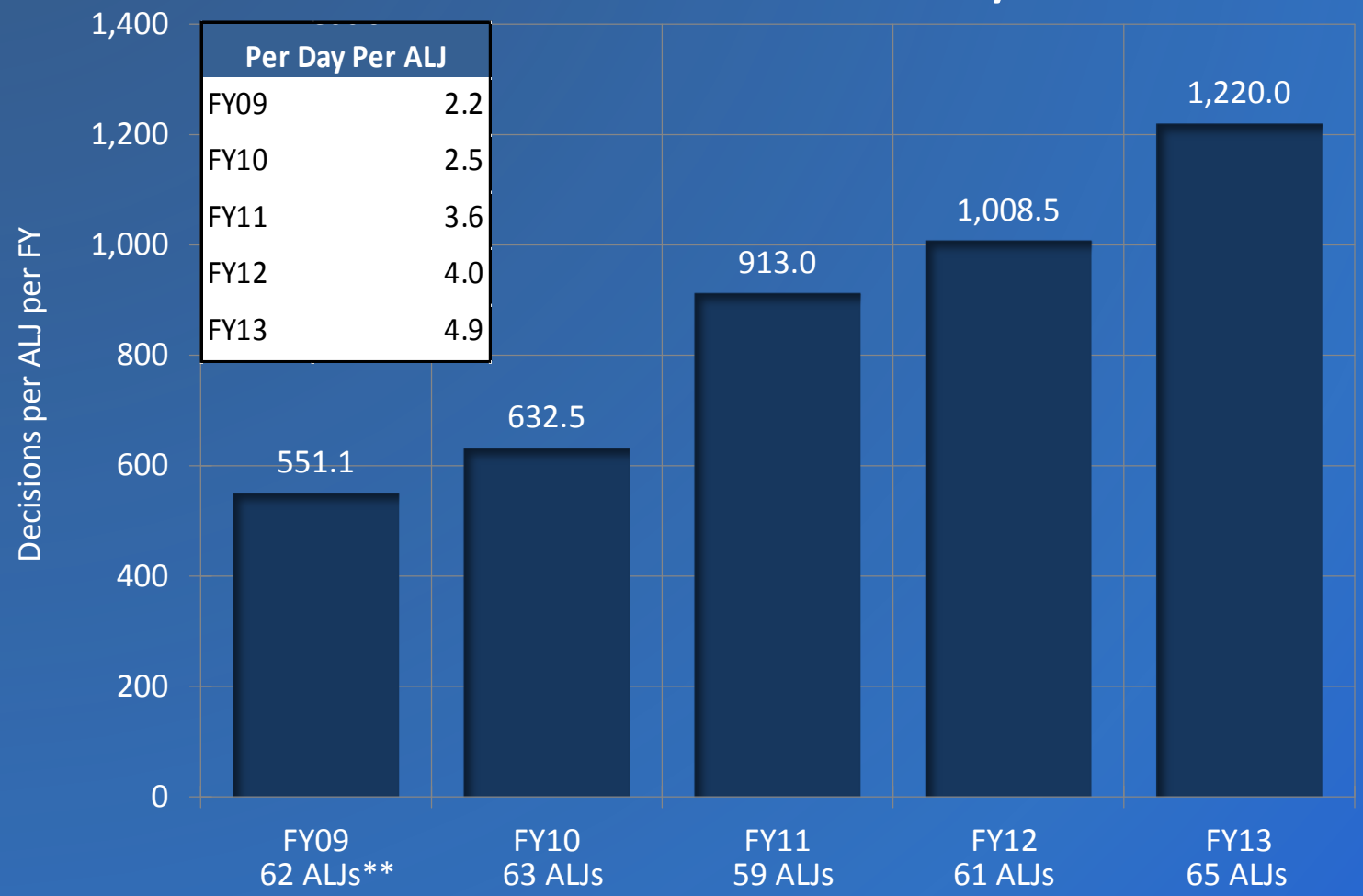


*Includes appeals with a request for hearing (RFH) date in listed year.
**Excludes reopened appeals and claims.
***FY13 includes receipts from Q1-Q3 only.

Run Date: January 24, 2014

OMHA Workload

ALJ Productivity



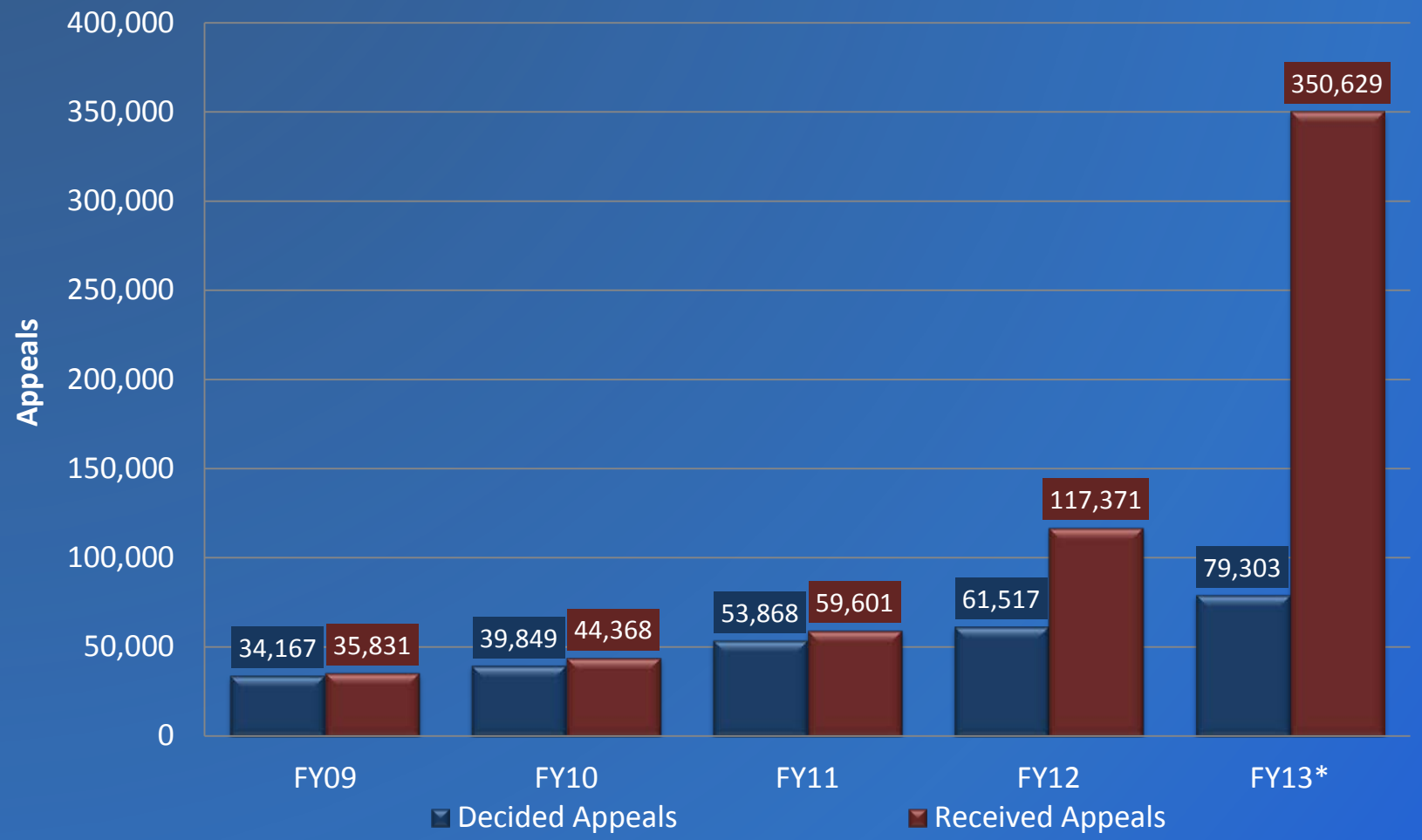
Per Day Per ALJ	
FY09	2.2
FY10	2.5
FY11	3.6
FY12	4.0
FY13	4.9

*Appeals decided in listed fiscal year; excludes remands
**Avg. ALJs during the fiscal year

**Run Date: January 13, 2014

OMHA Workload

Appeals Received and Decided By Fiscal Year



*Includes appeals with a request for hearing (RFH) date in listed year. FY13 receipts are estimated.

**Excludes Remands and Reopenings.

Run Date: January 24, 2014

OMHA Workload

- Reasons for increase in receipts
  - Continuing expansion of all post-payment audit programs
  - More active State Medicaid Agencies
  - Increase in Medicare beneficiaries

OMHA Workload

- Workload versus Resources
  - Although receipts increased, OMHA resources remained relatively constant
    - Reduction in FY13 due to sequestration
  - Recently approved FY14 budget
    - 18.6% increase in appropriation over FY13 operational level

Effect of Workload

- Physical space
  - As receipts increased, the number of paper case files at OMHA also increased
    - OMHA converted existing space to storage of the paper case files
    - However, insufficient space to keep up with the volume

Effect of Workload

- Centralized Docketing
  - 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
      - As of January 24, 2014, estimated delay of up to 28 months until assignment to an ALJ
    - Exceptions
      - Beneficiary-initiated appeals

Effect of Workload

- ALJ Teams
  - The estimated average wait time to obtain a hearing after assignment to an ALJ exceeds 6 months
    - Expected to continue as we work through the backlog
  - Results in an increase in processing time

Effect of Workload

Average Processing Time By Fiscal Year

Fiscal Year	Number of Days
FY09	94.9
FY10	109.6
FY11	121.3
FY12	134.5
FY13	220.6
FY14	
October	301.1
November	326.0
December	343.6
FY14 YTD Avg.	**329.8**

*Includes appeals decided in the listed fiscal year (does not include remands).
**Average days from request for hearing (RFH) to Decision.

***Run Date: January 23,2014

OMHA Initiatives

- Central Time Zone Office
- Programmatic Initiatives
  - OMHA Adjudication Manual
  - Statistical sampling
  - Mediation
- IT Initiatives
  - Website for viewing appeal status online
  - Electronic Case Adjudication and Processing Environment (ECAPE)

Reducing Processing Time

- Comply with the requirements for a request for hearing
  - Ensure a complete request
  - Send a copy of the request to the other parties

Reducing Processing Time

- Do not submit duplicate requests for hearing
- 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

Introduction

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

Policy Update

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

Division Responsibilities

- OMHA case processing policy and guidance
- Inter-agency case processing coordination
- Adjudication quality
- Administer the Appellant Climate Survey

OMHA Website

www.hhs.gov/omha/

- Adjudication timeframes (updated after the 15th of the month)
- Information on assignment of requests filed after April 1, 2013
- Escalation rights and process
- Information on CMS Ruling 1455-R (Part B Billing Options for Denied Part A Hospital Claims)

Initiatives to Address Workload

- Case Processing Efficiencies
  - Provide more information on OMHA case processing procedures and how we address procedural issues
  - Leverage demonstrated efficiencies
  - Ensure compliance with rules
  - Provide adjudicators with more information
- Alternate Adjudication Models
  - Provide more tools/options for reaching resolution
  - Use pilots to demonstrate viability

Case Processing Efficiencies

OMHA Adjudication Manual

- Day-to-day implementation of procedural rules
- Adopt most effective case processing practices — be efficient while maintaining quality

- *Goals*:
  - More consistency across adjudicators while preserving discretion to address unique circumstances of a case
  - A framework to move to an electronic process
  - Basis for revised forms

- *Examples*:
  - Request processing (copy requirement)
  - Front-end reviews for procedural issues
  - Hearing scheduling process

Alternate Adjudication Models

Models being <u>considered</u>:

- Statistical Sampling
  - Requested/Offered sampling and extrapolation to adjudicate appeals
  - OMHA-provided statisticians
  - Using valid statistical sampling models
- Mediation of Claims
  - OMHA facilitated mediation of claims
  - "Agreed Decisions"

Alternate Adjudication Models

Models being <u>considered</u>:

- Attorney Case Reviews
  - OMHA attorneys to review records
  - Fast-track potentially favorable claims or narrow issues for hearing
  - Address procedural issues earlier in process
- Long Term — Regulations
  - Provide more tools for adjudication
  - Bring more efficiency to the adjudication process

Stay Tuned

www.hhs.gov/omha/

Introduction

Bruce Goldin
Director, Information Management & Systems Division
Office of Medicare Hearings and Appeals

IT Initiatives Impacting the Appeals Process

What they are and what they mean to you

Bruce Goldin
Director, Information Management & Systems Division
Office of Medicare Hearings and Appeals

IT Improvement Efforts

- OMHA has identified and is developing two IT efforts aimed at improving the claims processing experience
  - Interim Initiative – ALJ Appeal Status Information System (AASIS) Website
  - Interim Initiative – Medicare Appeals Template System (MATS)
  - Long-Term Initiative-Electronic Claims Adjudication and Processing Environment (ECAPE)

Interim Initiative – AASIS Website

- Website that provides public access to appeal status information
- Allows users to query multiple level 2 and/or level 3 appeal numbers
- Returns appeal data such as:
  - Field office assignment
  - ALJ assignment
  - Appeal status
  - Team phone number
- Accessed through the OMHA website
- Implementation Spring 2014

Interim Initiative – MATS

- Document generation system that uses fillable forms and population of data to create individualized templates
- Improves efficiency through increased data propagation
- Serves as the prototype for ECAPE document generation (long-term initatives)
- Implementation
  - Piloting in the Miami Field Office
  - Nationwide rollout scheduled for second quarter 2014

Long -Term Initiative - ECAPE

- Intended Functionality
  - Case Intake
  - Assignment
  - Workflow Management
  - Exhibiting
  - Decision Writing
  - Closing
  - Management Information
- Shared System of Record

Long Term Solution - ECAPE

Milestone	Anticipated Timeframe
RFP Issued	Winter/Spring 2014
Contract Award	Spring/Summer 2014
Release 1	Spring 2015
Release 2	Fall 2015
Release 3	Summer 2016

Planned Releases

Release 1

- Intake
- Electronic Filing of Request for Hearing

Release 2

Appeal Adjudication from Intake through case closure

Release 3

Appellant Portal

- Expanded Request for Hearing, Document Viewing, Notice of Hearing Acknowledgement, Enhanced Appeal Status

How Appellants will be Affected

- Case processing efficiencies
- Accessibility through the Portal
  - Electronic filing of Request for Hearing
  - Submission of electronic evidence
  - View file electronically
  - Communication to and from OMHA

Introduction

Jane Cironi
Director, Central Operations Division
Office of Medicare Hearings and Appeals

The Request for ALJ Hearing

Jane Cironi
Director, Central Operations Division
Office of Medicare Hearings and Appeals

What is Central Operations?

- Created in 2012 to unify OMHA's national docketing and assignment functions
- OMHA's National Request for Hearing Processing Center

Goals

- Explain OMHA Central Operation's Processes
- Identify Common Filing Issues
- Provide Best Practices

Agenda

- Central Operations Workflow
- Completing the Request
- Request Attachments
- Duplicate Requests
- Complex Requests

Qualification

- For the purpose of this presentation, all regulatory references and CO Workflow descriptions assume we are discussing an appeal of a Part A/B QIC reconsideration.

Central Operations Workflow

Central Operations Workload

Workflow – Request Intake

Workflow – Request Intake

- Mail - Receiving approximately 15,000 Requests per week

- Day of Receipt
  - ❑Screen for Mail Stops
  - ❑Arrange in Work-bins by Date Received

- On Processing Day - 15 week wait time from receipt
  - ❑Open Mail and Apply Date Stamp
  - ❑Hole Punch Request and Attachments and affix in folder
  - ❑Group and Aggregate Requests
  - ❑Identify Misrouted Mail (e.g. ALJ Correspondence)

- No database entry at this stage
- OMHA can't answer questions about a Request at this stage

Workflow – Request Intake

- *File with the entity specified in the QIC reconsideration. 42 CFR 405.1014(b).*

- Central Operations

  200 Public Square, Ste. 1260

  Cleveland OH 44114

- Mail Stops
  - Attn: Escalation Request Mail Stop
  - Attn: 1455-R Withdrawal Mail Stop
  - Attn: Withdrawal Mail Stop

Workflow – Entry into Database

- OMHA Creates a record in our database identified by a unique ALJ#
- OMHA keys data extracted from your Request into this database
- Reconsideration data populates certain data fields
- The primary data element linking the reconsideration data to the ALJ# OMHA creates is the Medicare Appeal Number assigned by the QIC
- Production Timeframe: 21 week wait time from receipt

Workflow – Entry into Database

Core Principles

- One QIC Medicare Appeal Number to One ALJ Appeal Number
- A Medicare Appeal Number can be processed only once

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Appe[redacted]
Number: 1-1362007460

MAXIMUS
Federal Services

If you have questions, write or call:

MAXIMUS
Federal Services
QIC Part A East
3750 Monroe Ave
Suite 701
Pittsford, NY
14534-1302

Provider Inquiries

[redacted]

December 26, 2013

RE: Beneficiary: [redacted]
HIC #:
Appellant: JACKSON COUNTY HOME HEALTH, LLC

Dear Jackson County Home Health, LLC:

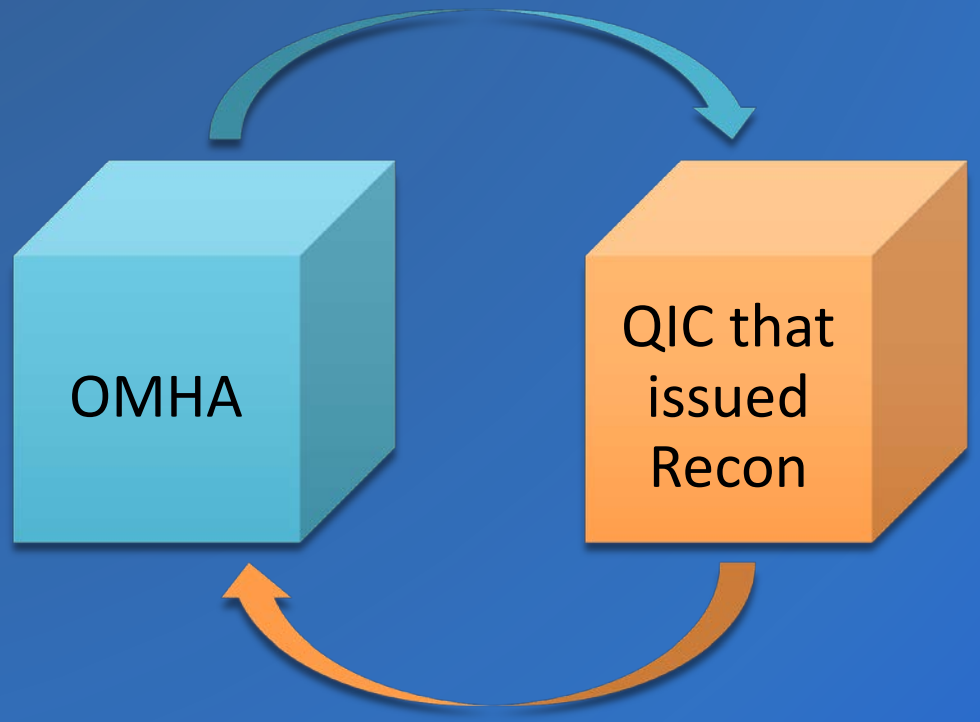
This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for home health services

Workflow – ALJ Assignment and Case File Request

- Paper Request stored until ALJ assignment
- 480,000 appeals awaiting assignment
- Assigned in Rotation and for Administrative Efficiency
- Request for Hearing is forwarded to ALJ for inclusion with the rest of the administrative record

Workflow – ALJ Assignment and Case File Request

- Central Operations submits case file request to QIC
- QIC ships case file to assigned ALJ



Workflow – ALJ Assignment and Case File Request

Case File Record Contents

- **All evidence previously submitted** with the original claim, at redetermination and at reconsideration.
- Procedural documentation – i.e. redetermination decision, reconsideration decision, original Medicare claim

Please do not re-submit evidence already submitted to prior levels of review

Completing the Request

Regulatory Requirements (See 42 CFR 405.1014)

1. Beneficiary Name, Address and Health Insurance Claim Number (HICN)
2. Appellant Name and Address
3. Designated Representative Name and Address
4. Document Control Number assigned by the QIC **(the Medicare Appeal Number)**
5. Dates of Service
6. Reasons you disagree with the QIC's reconsideration
7. Statement of any additional evidence to be submitted and the date it will be submitted

How Certain Data is Used

- **Medicare Appeal Number**
- Beneficiary Name and full HICN
- Name of QIC that processed your reconsideration

Common Issues Involving Key Data Elements

- Missing Medicare Appeal Number
- Inaccurate Medicare Appeal Number (e.g. missing a digit)
- Mismatch between Medicare Appeal Number, Beneficiary name and/or HICN

Other Common Issues

- Premature Requests
- Request Mailed to Wrong Entity
- Timeliness
  - File 60 Calendar Days from the date of receipt of QIC reconsideration
  - Extension Request (Form HHS-727) filed with Request, not in advance

Best Practices Summary

- Prominently list the Medicare Appeal Number on your Request
- Ensure that the Beneficiary information matches your Medicare Appeal Number
- List the Beneficiary's full HICN
- Please include the first page of the QIC decision OR prominently list the Full Name of the QIC
- We encourage use of form CMS-20034 A/B
- Document that you provided Proof of Service to the other parties identified on reconsideration
- Mail your Request via tracked mail to Central Operations

Request Attachments

Requests with Large Attachments

- Contents are largely duplicative of case file OMHA receives from QIC
- Creates space issues and shipping burden
- Impacts processing time

Impact of Additional Filings after the Submission of the Request

- May not be able to associate the Filing with the Request
  - Electronic ALJ File may not exist when the mail is received
- Best to submit directly to Assigned ALJ
  - Ensures filing is immediately associated with Appeal
  - Places the filing directly before the ALJ for consideration

Special Instruction for Providers or Suppliers

If you are submitting new evidence to the ALJ that was not previously submitted at any prior level of appeal, the evidence must be accompanied by a statement explaining why the evidence was not previously submitted. *See* 42 CFR § 405.1018.

The ALJ will then examine any new evidence to determine whether there was good cause to submit the evidence for the first time at the ALJ level. 42 CFR § 405.1028.

Best Practices Summary

- Please Limit Request Attachments to the following:
  - Appointment of Rep (if appropriate)
  - First Page of QIC Decision
  - Proof of Service to the other parties identified on reconsideration
- Please do not submit evidence already submitted to lower level
- Please do not attach evidentiary submissions to Request **or** submit Additional Filings to Central Operations
  - Submit directly to ALJ once you receive notice of assignment or within 10 days of notice of hearing

Duplicate Requests

Duplicate Request

A duplicate Request occurs when two or more Requests reflect the same Medicare Appeal Number

A Medicare Appeal Number can be used **only once** to establish an ALJ record

Common Reasons Duplicate Requests Occur

- Appellant resubmits their Request
- Filing multiple Requests for **One** Multi-Beneficiary Reconsideration
  - Appellant files a separate Request for each Beneficiary referenced on the same Medicare Appeal Number
- Appellant furnishes the QIC a Courtesy Copy of Request
  - QIC redirects to OMHA as a misrouted original Request

Best Practices Summary

- Submit Requests to OMHA via Tracked Mail
- Use Shipment Tracking Number to Verify Delivery
- Submit only one Request per Medicare Appeal Number
- Do not submit courtesy copy of the Request to the QIC

Complex Filings

Complex Filings

Multi-Beneficiary Reconsideration Decision

Grouped Hearing Requests

Aggregation Requests

Complex Filings (Con't)

Multi-Beneficiary Reconsideration

- **Single Medicare Appeal Number**

Only one ALJ# can be established

Best Practices

- Submit a single Request
- On the ALJ Hearing Request form, enter **"Multiple"** where it asks for Beneficiary and Date of Service information
- **Attach a list** with Beneficiary information and Dates of Service to the single Request for Hearing

Grouped Hearing Requests & Aggregation Requests

Best Practices

- Prepare a **separate Request form for each Medicare Appeal Number** you seek to group or aggregate
- Prominently Provide Grouping or Aggregation Language On Cover letter
- Submit all the requests in **one package**
- Only combine same level 1 Medicare Appeals Contractor (e.g. Novitas, NGS)

Package will be kept together and assigned to one ALJ

Resources

- Tips for Filing Requests for Hearing
- Please visit our website - www.hhs.gov/omha

Office of Medicare Hearings and Appeals

Medicare Appellant Forum

Wednesday, February 12, 2014

Lunch Break

The Forum will resume promptly at 1:45 p.m.

Please
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3:45 p.m.. - 4:45 p.m.	**Medicare Appeals – Levels I through IV – Q&A Forum**
4:45 p.m.. - 5:00 p.m.	**Closing Remarks**

Introduction

Judge C.F. “Spike” Moore
Deputy Chief Administrative Law Judge
Office of Medicare Hearings and Appeals

The Administrative Hearing
Appellant Do's & Don'ts

Judge C.F. "Spike" Moore
Deputy Chief Administrative Law Judge, OMHA

Judge Robert Fisher
Acting Associate Chief Administrative Law Judge, Midwestern Office

Judge Jeffrey Gulin
Supervisory Administrative Law Judge, Mid-Atlantic Field Office

Judge William Farley
Supervisory Administrative Law Judge, Mid-Atlantic Field Office

Introduction

Mike Crochunis
Director, Division of Appeals Operations
Centers for Medicare and Medicaid

Medicare Appeal Levels I & II

Overview and Update

Mike Crochunis
Director, Division of Appeals Operations
Centers for Medicare and Medicaid

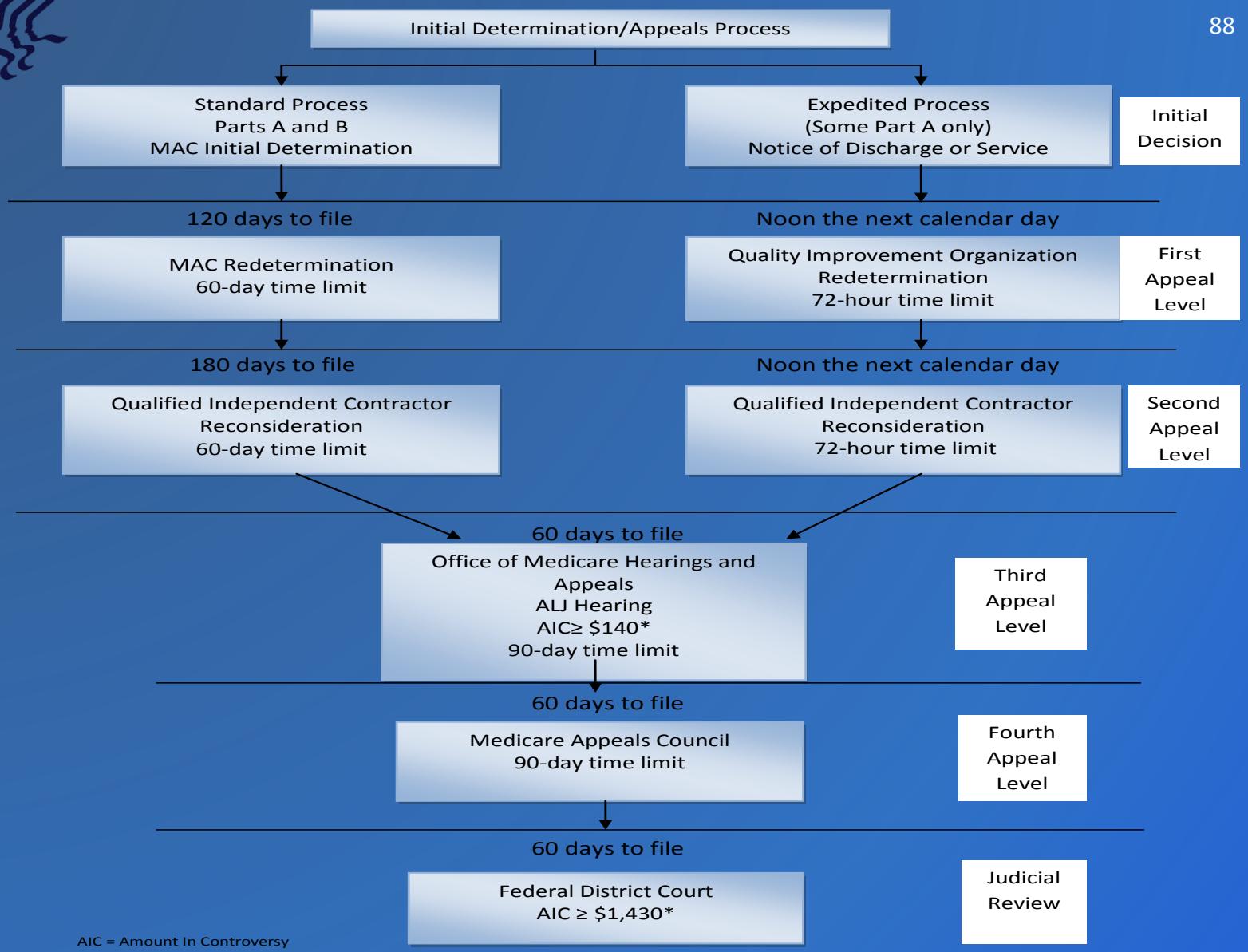
Agenda

- Fee-For-Service (FFS) Claim Appeals Process
- Trends
- Tips on Submitting Appeals
- Increasing Efficiencies

FFS Claim Appeals Process: Goals

- Reduce improper payments
- Resolve appeals consistently and as quickly as possible at the lowest level
- Have clear coverage policies that are applied consistently
- Share information to improve the process

FFS Appeals Process

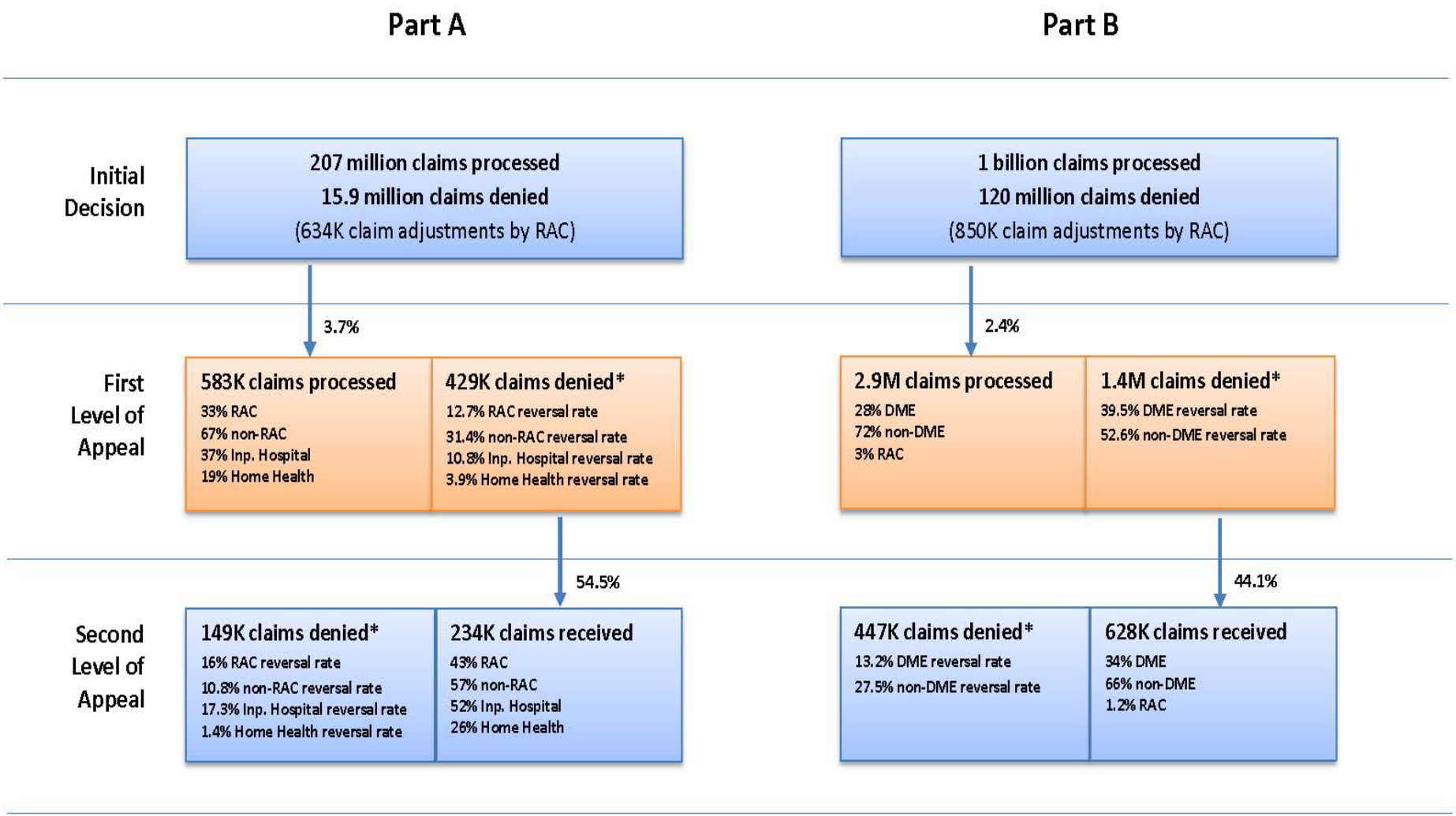


AIC = Amount In Controversy
ALJ = Administrative Law Judge
MAC = Medicare Administrative Contractor
*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2014.

Fee-For-Service Appeals Contractors

- Proposed structure: 10 A/B Medicare Administrative Contractors (MACs) and 4 Durable Medical Equipment (DME) MACs for redeterminations
- 2 Qualified Independent Contractors (QICs) for Part A reconsiderations
- 2 QICs for Part B reconsiderations
- 1 QIC for DME reconsiderations
- Administrative QIC "AdQIC"
  - Data analysis, Appeals Council referrals, and clearinghouse for QIC and ALJ case files

Medicare FFS Appeals Data Overview - FY 2012



*Includes fully affirmed and partially reversed claims. Reversal rates do not include dismissed claims.

Estimated CY 2013 Appeals Workload

Processed at Level 1
Parts A & B

- **Remanded/ Dismissed** (8%)
- **Favorable** (30%)
- **Partially Favorable** (3%)
- **Unfavorable** (59%)

Processed at Level 2
Parts A & B

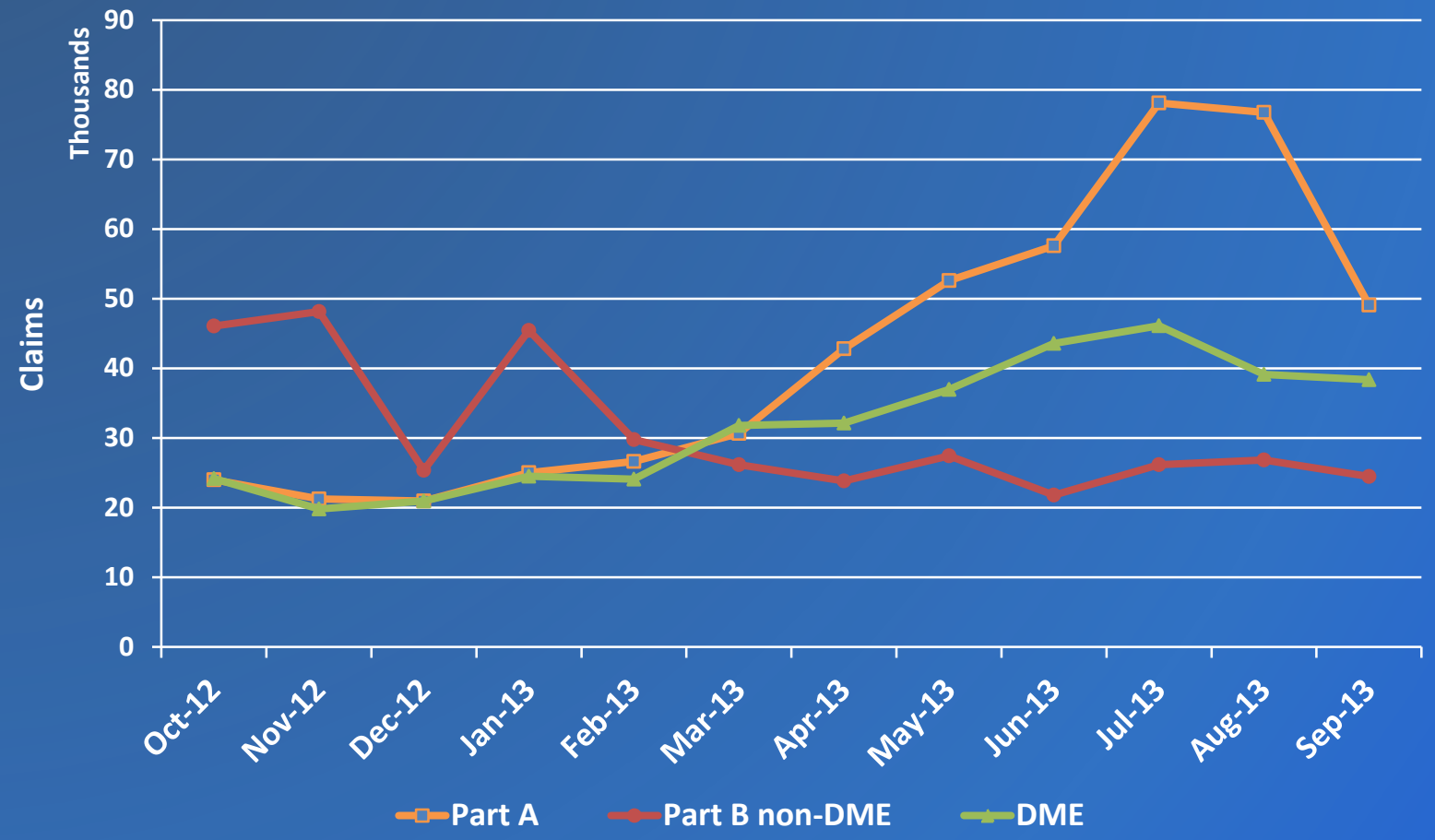
- **Remanded/ Dismissed** (7%)
- **Favorable** (14%)
- **Partially Favorable** (1%)
- **Unfavorable** (79%)

**Values are in claims*
***2.5% denied claims from Initial Determination*

QIC Timeliness - CY 2013

Expedited Part A Appeals					
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	CY 2013
Part A	99.8%	100.0%	99.9%	99.9%	99.9%
Standard Part A Appeals					
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	CY 2013
Part A	10.8%	6.3%	30.1%	89.1%	35.8%
Overall					
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	CY 2013
Part A	12.6%	7.2%	30.6%	89.2%	36.5%
Part B	99.7%	99.8%	99.9%	99.9%	99.8%
DME	99.9%	99.9%	100.0%	99.9%	99.9%

QIC Productivity



Average Days to QIC Decision

Part A – 97.8 Part B – 54.2 DME – 52.9

Appeal Submission Tips

- Consolidate as many similar claims as possible into one appeal request starting at Level 1
- Consider providing advance permission to sample claims to extrapolate the total
- File requests timely with the appropriate contractor
- Include all required items and, most importantly, sign your request for appeal

Appeal Submission Tips (cont.)

- Include a copy of the decision letter issued at the previous level
- Include a copy of the demand letter if appealing an overpayment determination
- Include a copy of the Appointment of Representative (AOR) form if representing a provider/supplier/beneficiary
- Respond promptly to contractor requests for documentation

Effectuation of ALJ Decisions

- ALJs send cases and decisions to AdQIC for processing and storage
- AdQIC reviews decision and decides whether to refer to the Appeals Council within 10 days
- If not referred, the AdQIC sends decision and effectuation notice to MAC
- MAC has 30 days to effectuate or 60 days when calculation of the payment amount is required
- Appeal Status on the Q2A.com website updated to 'MAC Effectuation'
- Subsequent questions directed to the MAC

Appeals Status Updates

- www.Q2A.com, active appeals search
- Use QIC or ALJ appeal number

Limitation on Recoupment (935)

- Recoupment does not begin if a valid redetermination request is received within 30 days
- Recoupment starts between 61 and 76 days after the redetermination
- Recoupment does not begin if a valid reconsideration request is received within 60 days
- Recoupment stops when the QIC notifies the contractor that a valid request for a reconsideration has been received
- Recoupment resumes 30 days after the QIC reconsideration, regardless of an ALJ hearing request

Increasing Efficiencies in the Appeals Process

- Expand use of the Medicare Appeals System
- Transmit files electronically
- Participate in OMHA's Educational Symposia

Increasing Efficiencies in the Appeals Process (cont.)

- Sponsor contractor and HHS workgroups
- Evaluate contractor performance
- Analyze ALJ decisions to improve contractor decision letters

Introduction

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

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 (if necessary)

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 one of the following actions:

-Adopt -Reverse

-Modify -Dismiss

-Remand

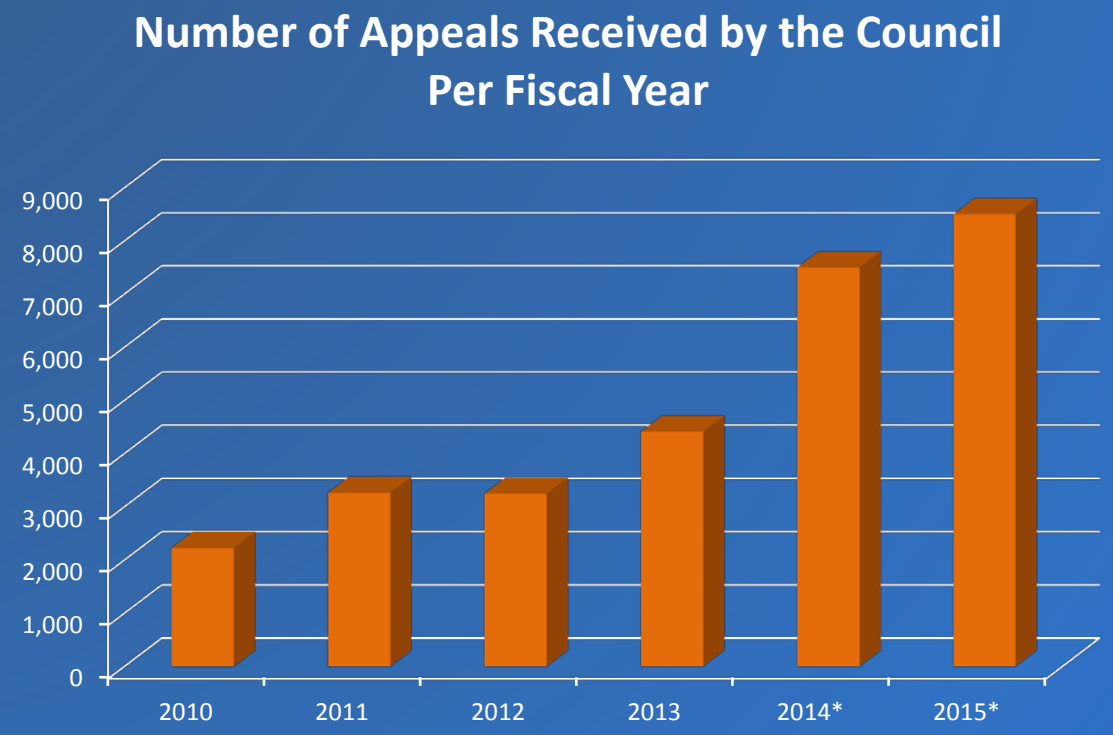
Council decisions can be appealed to federal court IF the amount in controversy is met ($1,430 in 2014)

Status of Appeals at the DAB

The number of requests for Council review is steadily increasing:

- In FY 2013, the Council closed 2,592 appeals (13,412 individual beneficiary claims) the largest number in the history of the organization.
- By the end of FY 2013, the number of pending appeals was 4,888. This is 112% more than at the end of FY 2012.

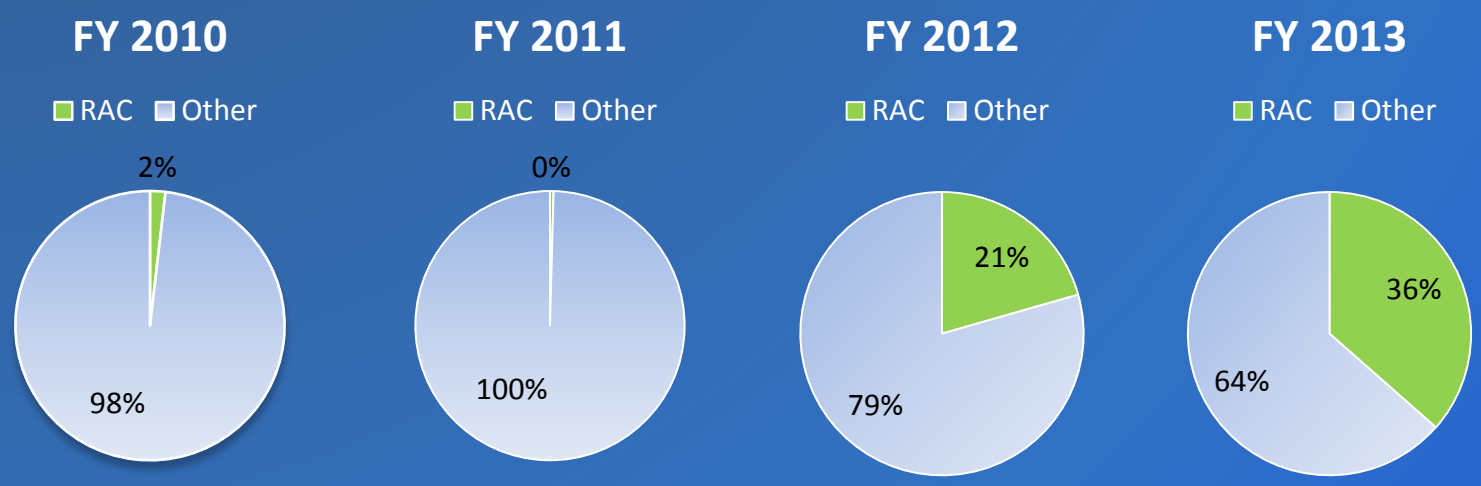
MOD WORKLOAD PROJECTIONS



**These numbers are based on OMHA workload predictions*

Increase in the MOD Caseload

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

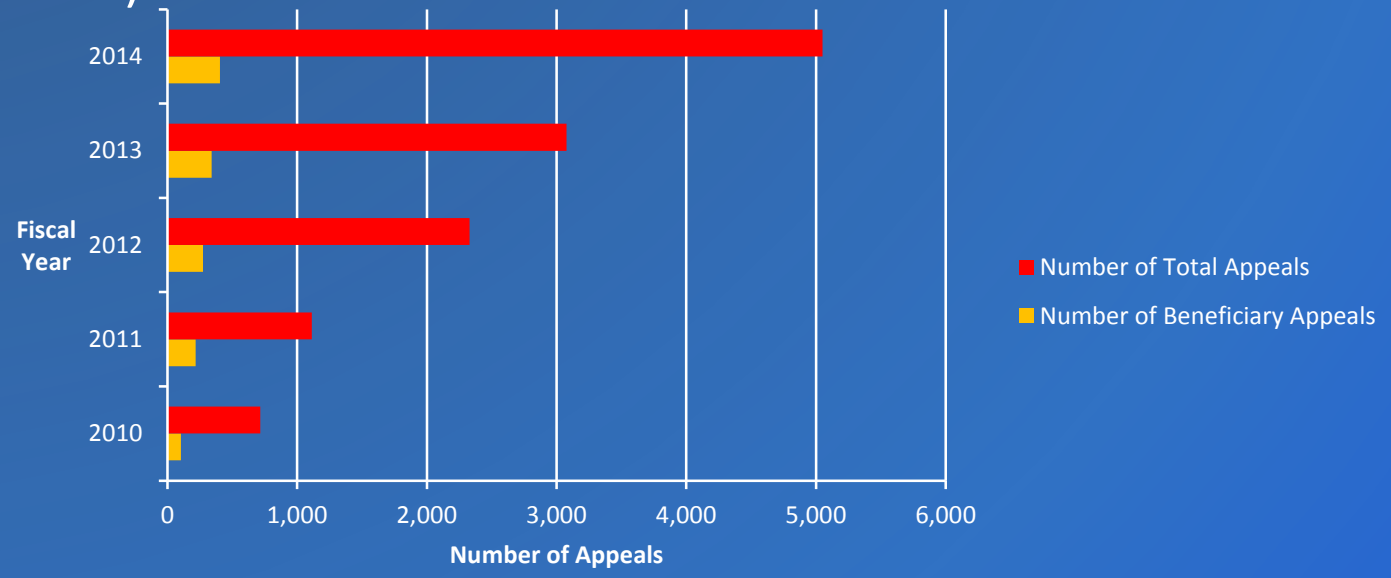


Managing the Increasing Caseload: Council's Actions

- Beneficiary-Focus
- Process Improvement
  - e-Records
  - Appeal consolidation

Beneficiary-Focus

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



Process Improvements- e-Records

- Pilot program- working with contractors to receive claim files electronically in cases in which CMS seeks own motion review (Agency Referrals)
- Eliminates the work involved with moving/storing paper files, increases the efficiency of document transmittal
- Expanding the use of electronic records to other types of cases, eventually working towards receiving e-records in all cases

Process Improvement- Appeals Consolidation

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

Managing the Increasing Caseload: PRACTICE TIPS

- Requests for Review
  - Acknowledgment Letter
- Escalations
  - Escalations from OMHA to the Council
  - Escalations from the Council to Federal Court

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.

ESCALATIONS

- Escalation requests from OMHA to the Council:
  - In FY 2013, the Council received 7 escalation requests from OMHA to the Council
  - In FY 2014, the Council has already received a total of 19 escalations from OMHA

PRACTICE TIP:
Escalations from OMHA to Council

- Two-Step Process:
  1) The appellant must file a written request for escalation with OMHA. OMHA then issues a decision, dismissal, remand, or a Notice of Escalation Request.

  2) If no action by OMHA within 10 days (including 5 days for mailing time), the appellant can then file a request for escalation with the Council. The appellant must ensure that the request:
     - contains the required content for a request for review of an escalated case as set forth in the regulations;
     - is sent to both the Council and to the ALJ's OMHA office; and
     - is sent to the other parties to the appeal.

42 C.F.R. §§ 405.1104, 405.1106

Review of Cases Escalated from OMHA

- 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*
  - Take action within 180 calendar days beginning on the date the request for escalation is received by the Council
  - Issue a decision, dismissal, or remand to the ALJ for further proceedings

ESCALATIONS

- Escalation requests from the Council to Federal Court:
  - In FY 2013, there were a total of 2 escalation requests to federal court
  - In FY 2014, the Council has already received 6 escalation requests to federal court

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

Escalations from the Council to Federal Court

- If the appellant receives a notice from the Council that no decision will be issued, the appellant may then file an action in federal district court within 60 calendar days

Thank you for your attention.

Office of Medicare Hearings and Appeals

Medicare Appellant Forum

Wednesday, February 12, 2014

15 Minute Break

The Q&A Session will begin promptly at 3:45 p.m.
If you plan to ask a question, please line up behind the microphones.

Please
Mute your phone or place in vibrate mode

Introduction

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

Medicare Appeals
Question & Answer Forum

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

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

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

Closing Remarks

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

Office of Medicare Hearings and Appeals

Medicare Appellant Forum

Wednesday, February 12, 2014

Thank you for participating!

Please take the opportunity to visit us at
http://www.hhs.gov/omha
and complete the
OMHA Medicare Appellant Forum questionnaire