Central Operations Division Standard (Priority 3) Appeal Workflow

ERIN BROWN – ACTING DIRECTOR

11/10/2022

Agenda

Workflow Process Overview

Potential Roadblocks and Delays impacting case processing times

What's Next

Division of Central Operations Workflow Process

Intake Prep

Intake prep, receive mail, count, date stamp, open, sort, copy, prepare for scanning, folder, and route

Intake

Associate scan sheet with RFH; enter data into ECAPE; determine promotable; group associated appeals into intake groups; triage issues

Mass Production Scanning

San box of RFHs using barcoded scan sheets and associate with scanning box; Supervisor FTP scans into ECAPE; QA scans

Appeal Review

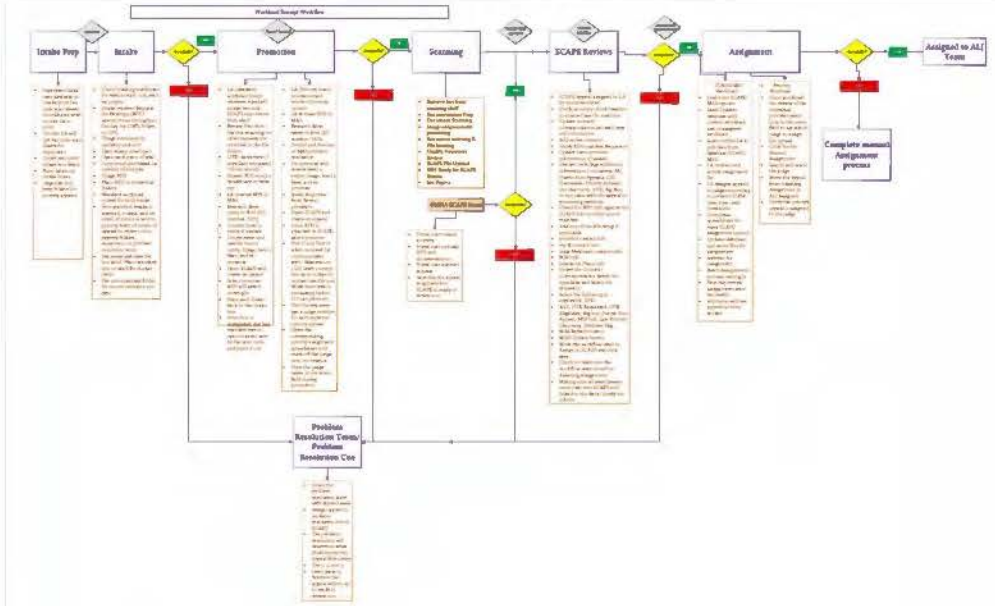
Scans uploaded to appeal = ready tor review; Supervisor assigns appeals to LAs for appeal review.

Appeal QA

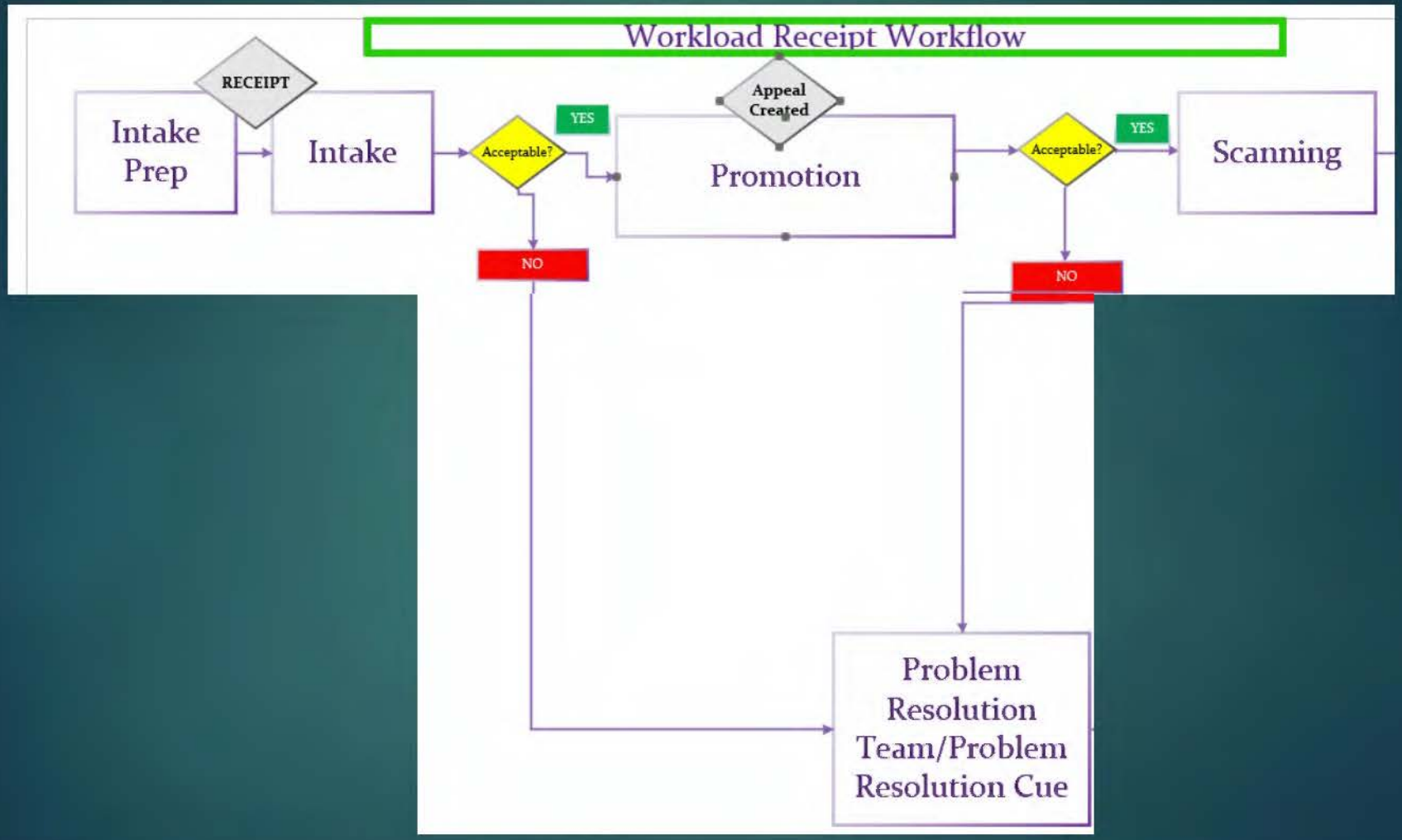
Supervisor assigns appeal to double check repository entries accepted/accurate, MBD data, entries accurate.

Appeal Assignment

Supervisor/Lead pulls list of assignable appeals from external database as well as ALJ dockets, determines needs, builds assignment list, enters into ECAPE, QAs and fixes errors.



Overview of Receipt to Assignment Workflow


Workload Receipt Workflow
RECEIPT
Intake Prep
Intake
Acceptable?
YES
NO
Appeal Created
Promotion
Acceptable?
YES
NO
Scanning
Problem Resolution Team/Problem Resolution Cue

Pre-ECAPE Docketing: Intake Prep

- External database: create bar code scan sheets for uploading RFHs to ECAPE.
- Print and stage bar code scan sheets for intake
- QA bar code scan sheets for duplicates
- Create and affix intake box labels for ECAPE tracking;
- Organize and prep RFH folders in intake BOX

Intake: Process Overview

1. Mail Receipt and Processing
   - Receiving, date stamping and screening mail.
2. Identifying, sorting, grouping, and in-processing workload
3. Staging workload for processing by priority
4. Scanning
5. Triaging and Problem Resolution

Pre-ECAPE Docketing: Intake Prep

Request for Hearings (RFH) received multiple times throughout the day (USPS, Fedex , or UPS).

Note: Exp Part D also comes by fax and phone.

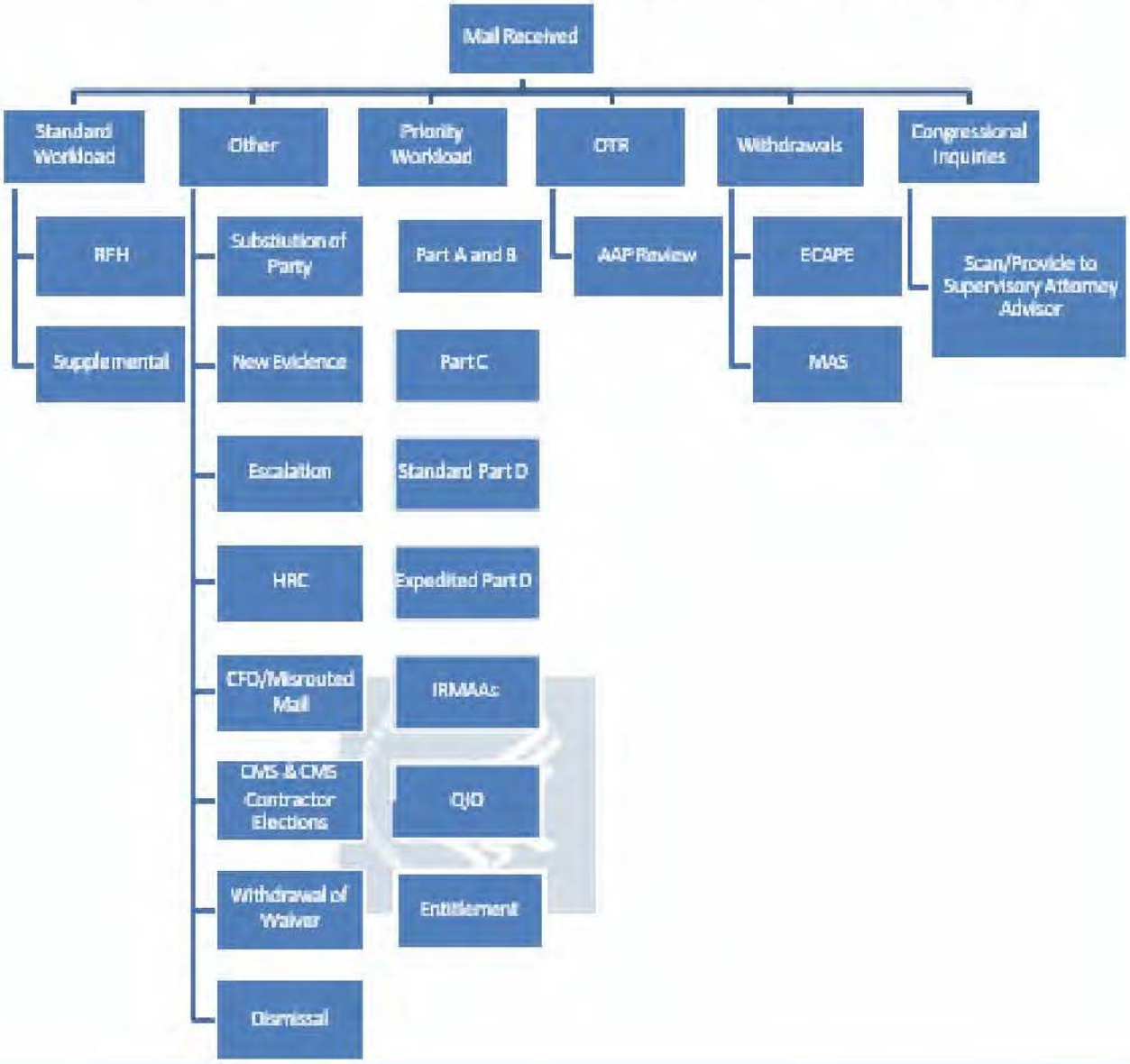
1. Envelopes/Package Triage:

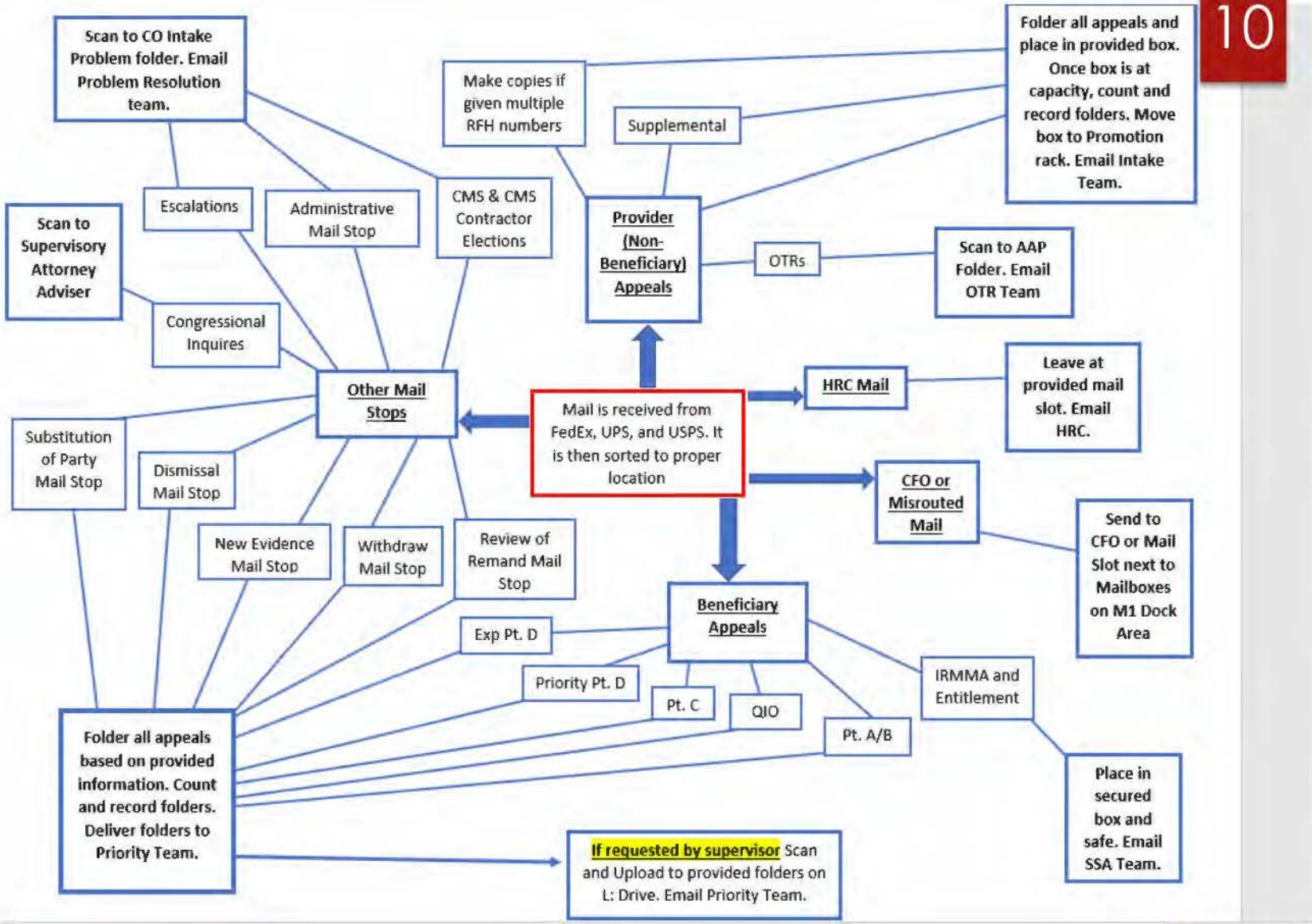
- Counted
- Date stamped
- Sorted by mailstop and other categories
- Copied based on OCPM requirements.

2. RFH and Other Submissions Triaged:

- Sorted based on RFH priority;
- Reviewed, copies made for multi-submissions/documents pertaining to multiple appeals;
- Date Stamped
- Individual appeal per folder made;
- Groups rubber-banded together;
- Standard workload (priority 3) is routed for bulk scanning and intake;
- Standard workload box is labeled for dated and labeled for intake and mass scanning.

Overview of Mail Intake




Scan to CO Intake Problem folder. Email Problem Resolution team.
Make copies if given multiple RFH numbers
Supplemental
Folder all appeals and place in provided box. Once box is at capacity, count and record folders. Move box to Promotion rack. Email Intake Team.
Escalations
Administrative Mail Stop
CMS & CMS Contractor Elections
Scan to Supervisory Attorney Adviser
Provider (Non-Beneficiary) Appeals
OTRs
Scan to AAP Folder. Email OTR Team
Congressional Inquires
Other Mail Stops
Mail is received from FedEx, UPS, and USPS. It is then sorted to proper location
HRC Mail
Leave at provided mail slot. Email HRC.
Substitution of Party Mail Stop
Dismissal Mail Stop
CFO or Misrouted Mail
Send to CFO or Mail Slot next to Mailboxes on M1 Dock Area
New Evidence Mail Stop
Withdraw Mail Stop
Review of Remand Mail Stop
Beneficiary Appeals
Exp Pt. D
Priority Pt. D
Pt. C
QIO
Pt. A/B
IRMMA and Entitlement
Folder all appeals based on provided information. Count and record folders. Deliver folders to Priority Team.
Place in secured box and safe. Email SSA Team.
If requested by supervisor Scan and Upload to provided folders on L: Drive. Email Priority Team.

Pre-ECAPE Docketing: Intake Problem Resolution

RFH LACKING INFORMATION
ADDRESS CHANGE REQUESTS
ESCALATIONS
RFH ON ESCALATION FORM
RFH ON HEARING WAIVER FORM
MISSING RFH
MISROUTED MAIL (i.e., DAB-101)
REQUESTS FOR RECONSIDERATION
QIC ERRORS
REMAND RETURNED FROM QIC
APPEAL STATUS REQUEST
WRONG JURISDICTION
NON-OMHA MATTERS

Scanning RFHs into ECAPE


ECAPE SCANNING SHEET
Information attached contains Personally Identifiable Information

If Found Return to:
OMHA Central Operations
1001 Lakeside Avenue, Suite 930
Cleveland; OH 44114

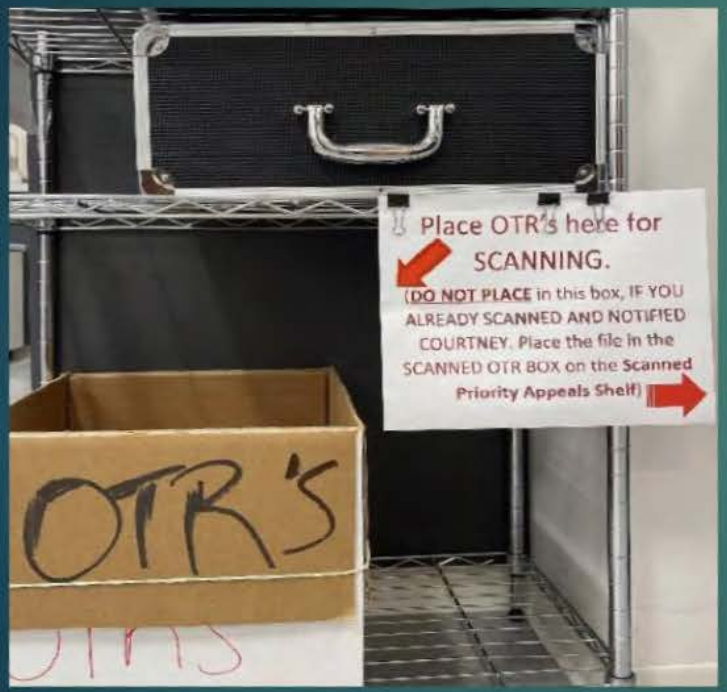
S-1000148511

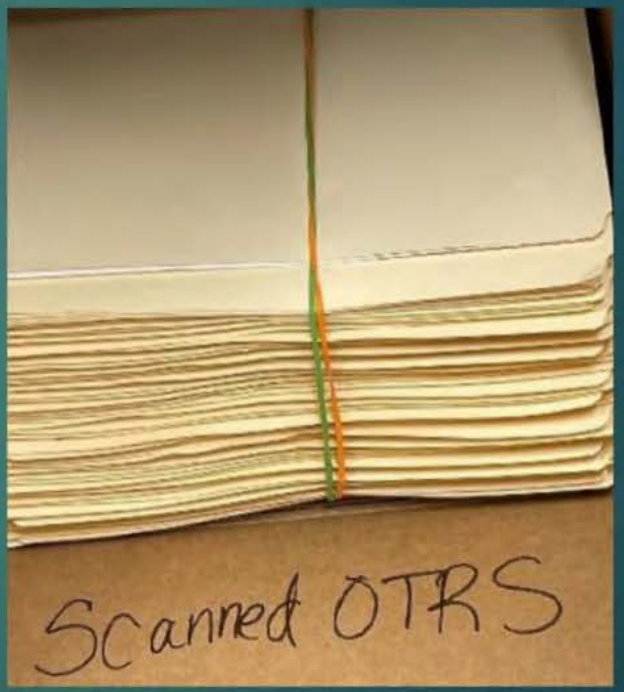
Using an external database, CO creates bar code scan sheets for uploading RFHs to ECAPE.

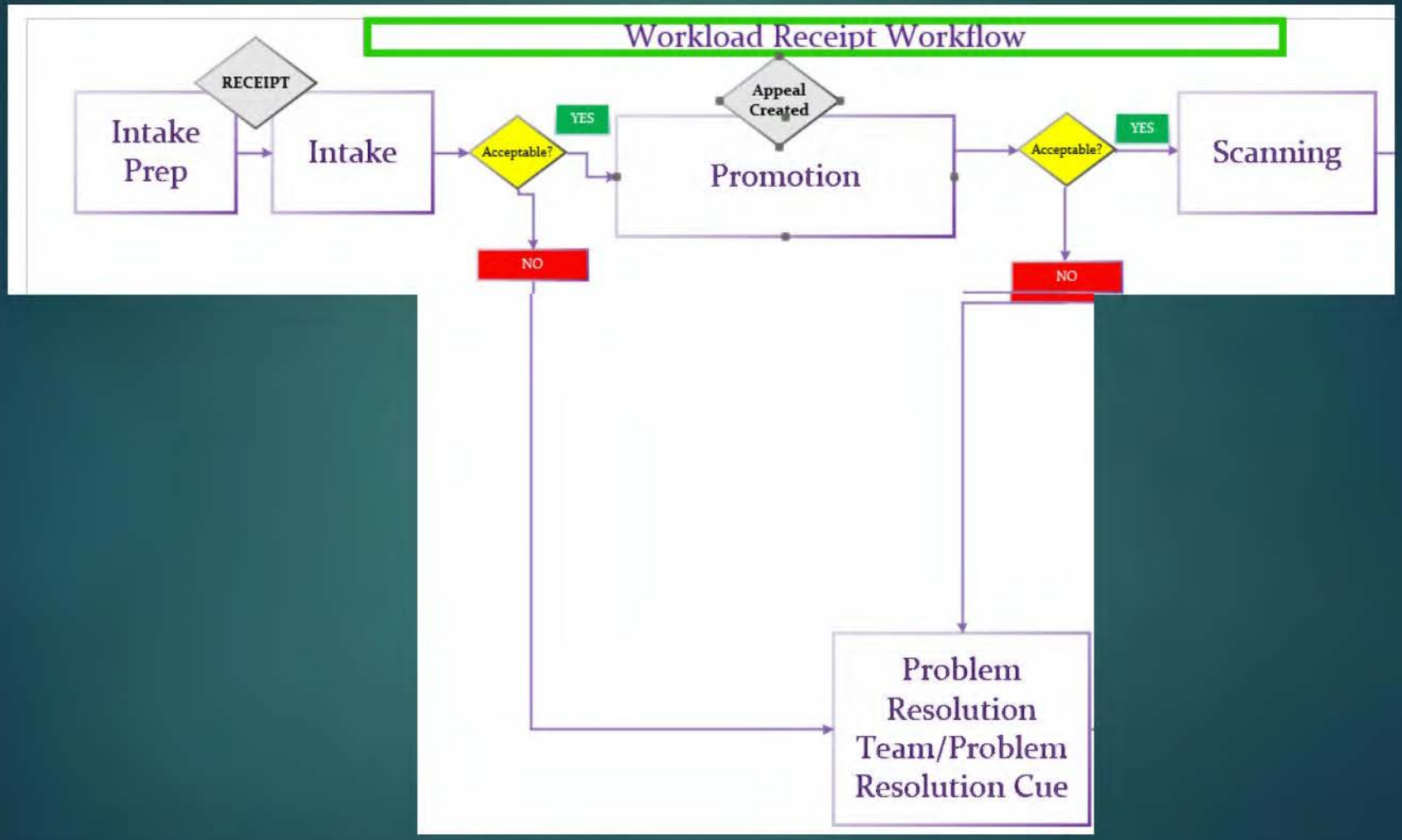
Priority 3 Intake Prep

Processing by rotation type; Grouping (rubber bands); Prioritization, storage and record management; Destruction

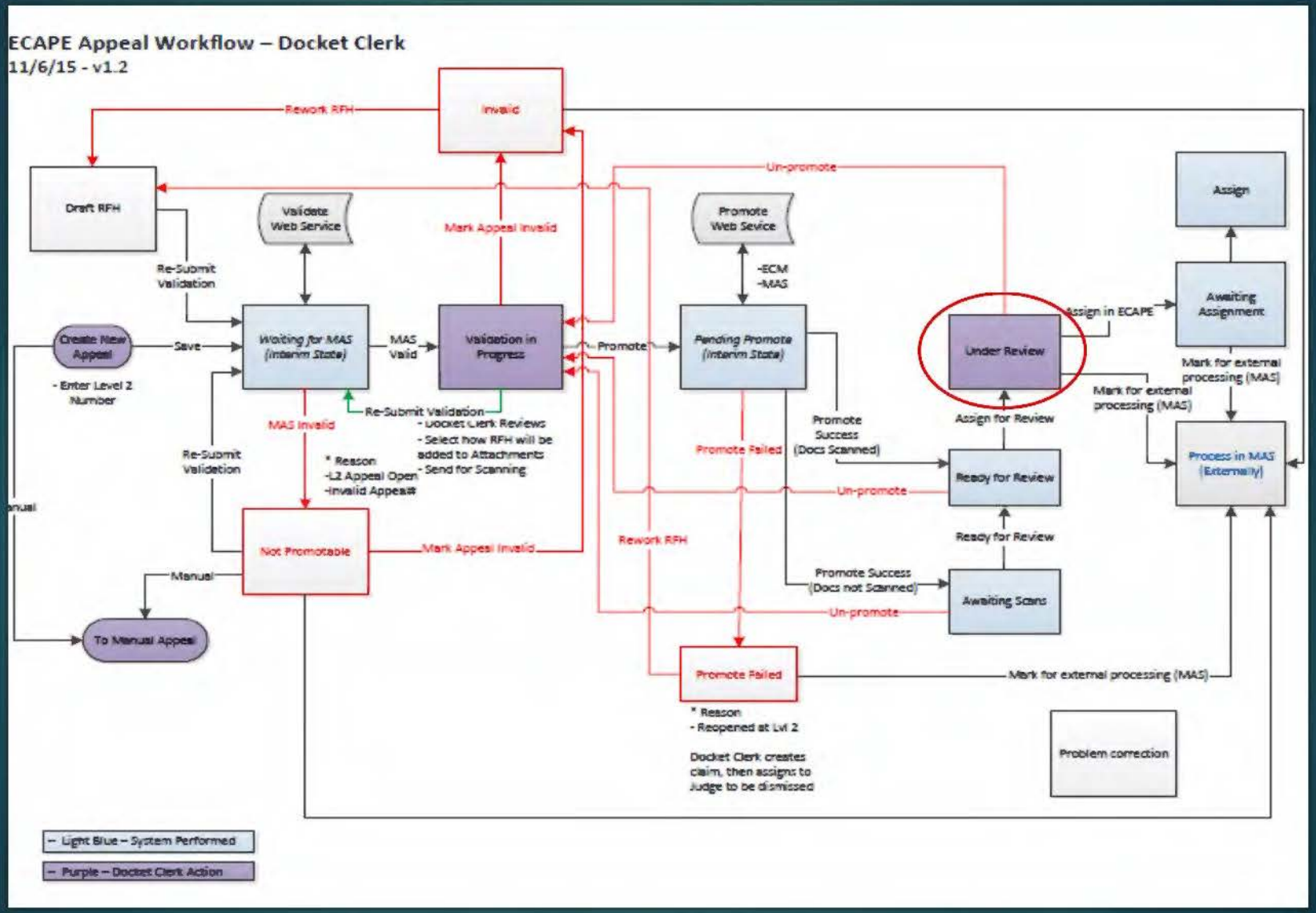
Requested OTRs

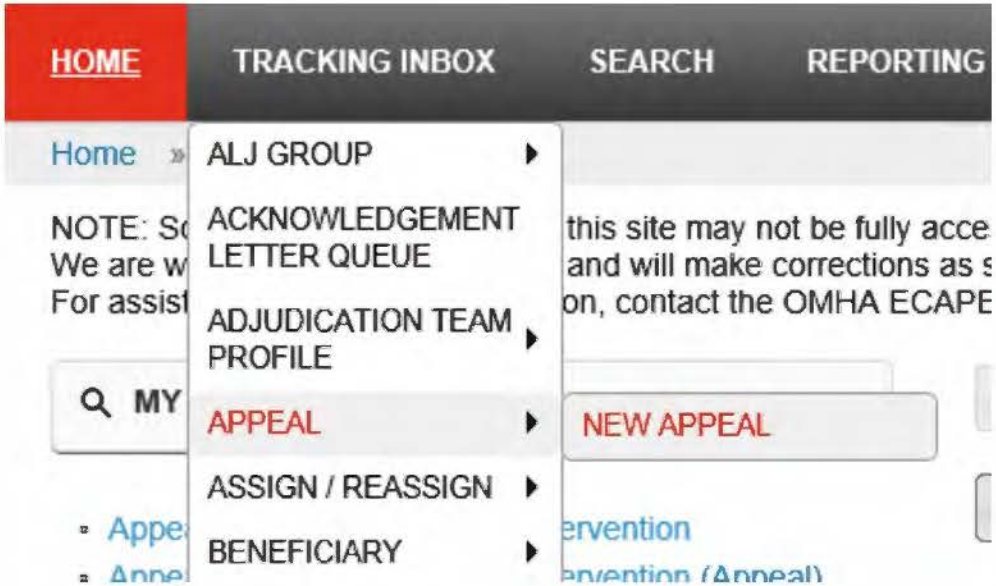





Workload Receipt Workflow
RECEIPT
Intake Prep
Intake
Acceptable?
YES
NO
Appeal Created
Promotion
Acceptable?
YES
NO
Scanning
Problem Resolution Team/Problem Resolution Cue

ECAPE


ECAPE Appeal Workflow – Docket Clerk
11/6/15 - v1.2
Invalid
Rework RFH
Draft RFH
Validate Web Service
Mark Appeal Invalid
Promote Web Sevice
Un-promote
Assign
Re-Submit Validation
-ECM
-MAS
Awaiting Assignment
Create New Appeal
Save
Waiting for MAS (Interim State)
MAS Valid
Validation in Progress
Promote
Pending Promote (Interim State)
Under Review
Assign in ECAPE
- Enter Level 2 Number
Mark for external processing (MAS)
Re-Submit Validation
MAS Invalid
- Docket Clerk Reviews
- Select how RFH will be added to Attachments
- Send for Scanning
* Reason
-L2 Appeal Open
-Invalid Appeal#
Promote Failed
Promote Success (Docs Scanned)
Assign for Review
Process in MAS (Externally)
Ready for Review
Un-promote
Re-Submit Validation
Not Promotable
Mark Appeal Invalid
Rework RFH
Ready for Review
Manual
Promote Success (Docs not Scanned)
Awaiting Scans
Un-promote
To Manual Appeal
Promote Failed
Mark for external processing (MAS)
* Reason
- Reopened at Lvl 2
Docket Clerk creates claim, then assigns to Judge to be dismissed
Problem correction
- Light Blue – System Performed
- Purple – Docket Clerk Action



Intake: ECAPE

Promotable or Non-Promotable Appeal: Promotable (R)

Reconsideration # (R)

Notes

Request Received Date (mm/dd/yyyy) (R)

Complete Request Received Date (mm/dd/yyyy) (R)

Date Case File Requested (mm/dd/yyyy)

Save

ECAPE ID	E401784
Reconsideration #	1-6949593104
Request Received Date	01/29/2018 (mm/dd/yyyy) R
Complete Request Received Date	01/29/2018 (mm/dd/yyyy) R
Incorrect Entity Received Date	(mm/dd/yyyy)

Validation

Validation Results

Reconsideration #	Validation Result	Reason	MAS Transaction ID	Created By	Created Date
1-947145646	Promotable		1468249044161378404	Matternas, Lena	2016-07-11 10:58:16.0

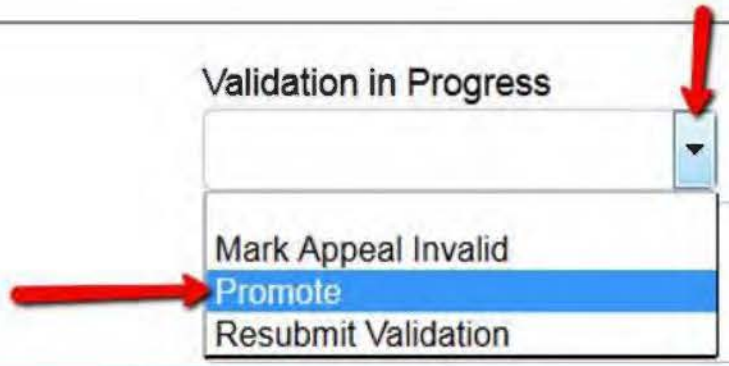
Level 3 Appeal #	Medicare Type	Appeal Disposition	DLM Date	NPI	Provider Name	HICN	Last Name	First Name	Claim	Service Start Date	Service End Date
	FFS-Part B of A	Unfavorable	06/11/2012 14:01:55			FNWJ3MFNWJ3M	FNWJ3M	FNWJ3M	21201800060208CTA	10/06/2011	10/06/2011

Workflow Information

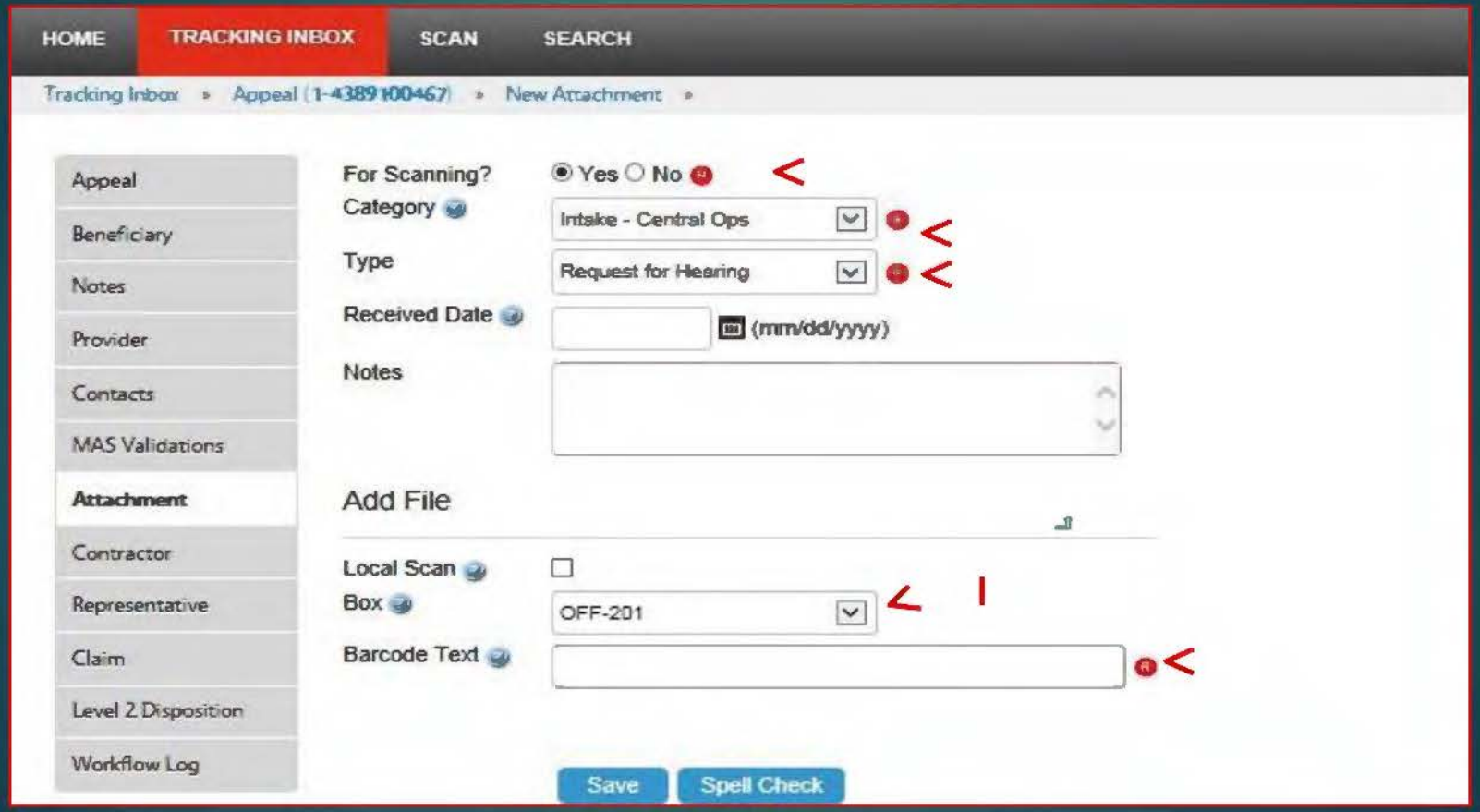
Appeal State: Validation in Progress

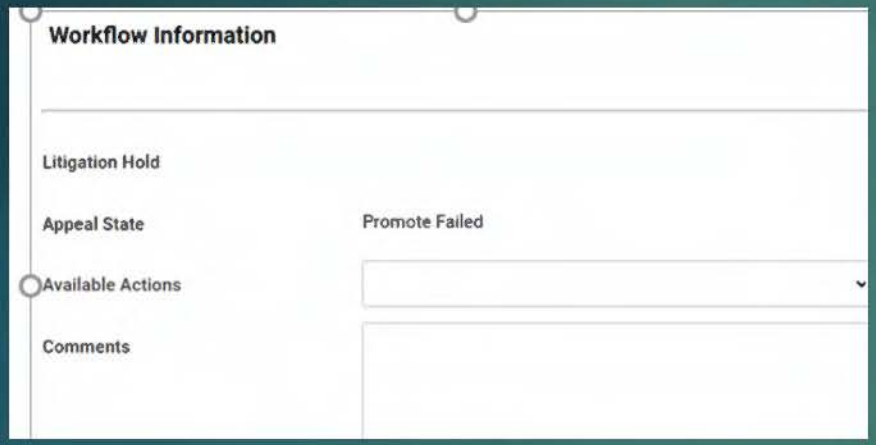
Available Actions

Comments



RFH placeholder and how the scan is associated.





If an appeal fails to promote, the appeal moves to CO's ECAPE Problem Resolution Queue for further development.

Show 10 entries

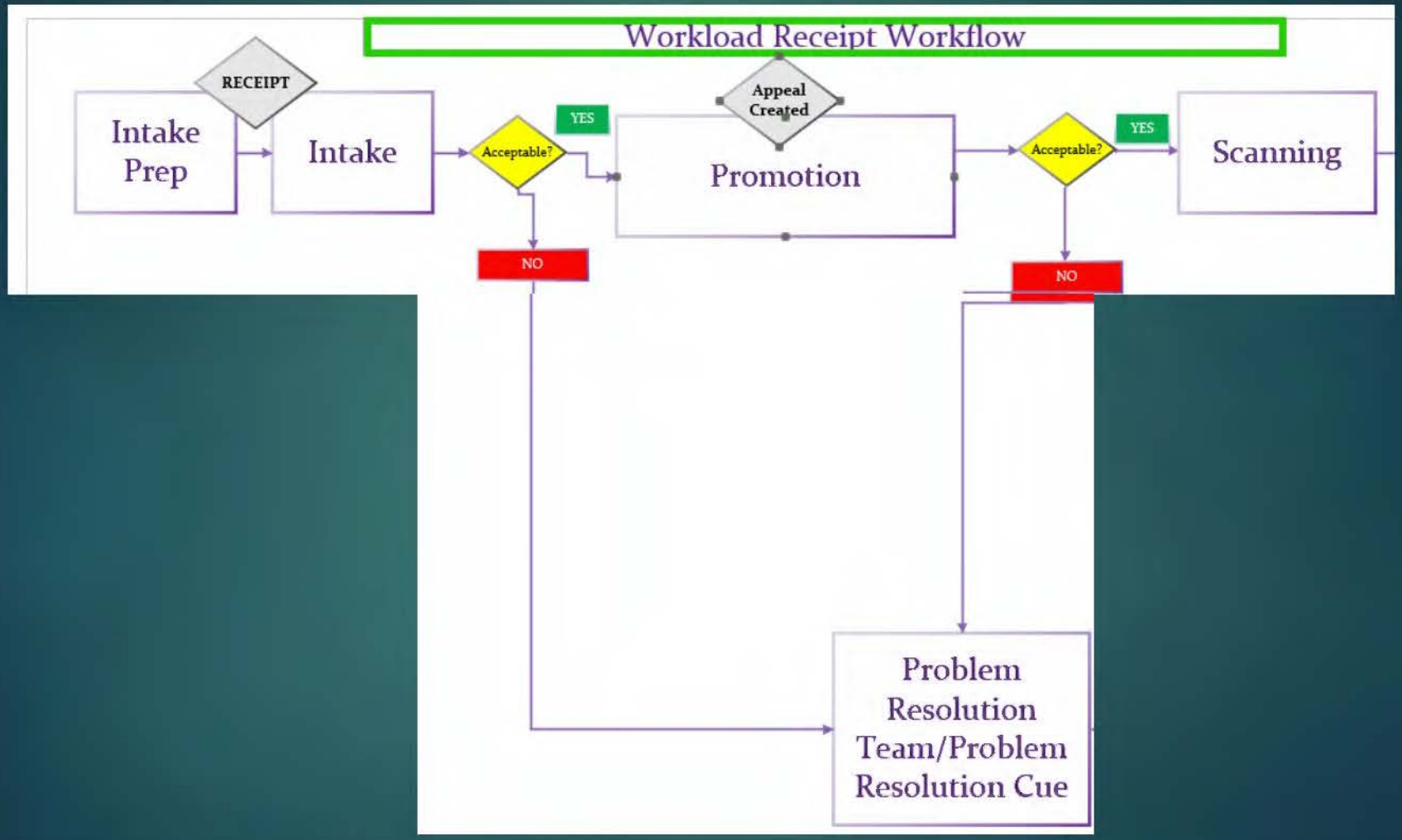
Search all columns:

ECAPE ID	Group ID	Appeal Priority	Complete Request Received Date	Provider Name	Assigned To	Assigned Date	Notes	Problem Description
E1071366M		4-Standard	2022/03/23	OLD MAN'S HOME OF PHILADELPHIA			Per the ECAPE product owner, this a...	Other (Notes Required)
E1114293		4-Standard	2022/08/29				INC-ECAPE0021401	Promote Failed
E1125033		4-Standard					1-11390964342 is not closed. The ap...	Promote Failed
E1128890		4-Standard					1121246107550 does not exist in MAS	Promote Failed
E1128895		4-Standard					1121263026110 does not exist in MAS	Promote Failed
E1130002		4-Standard					1-11357250947 is not closed. The ap...	Promote Failed

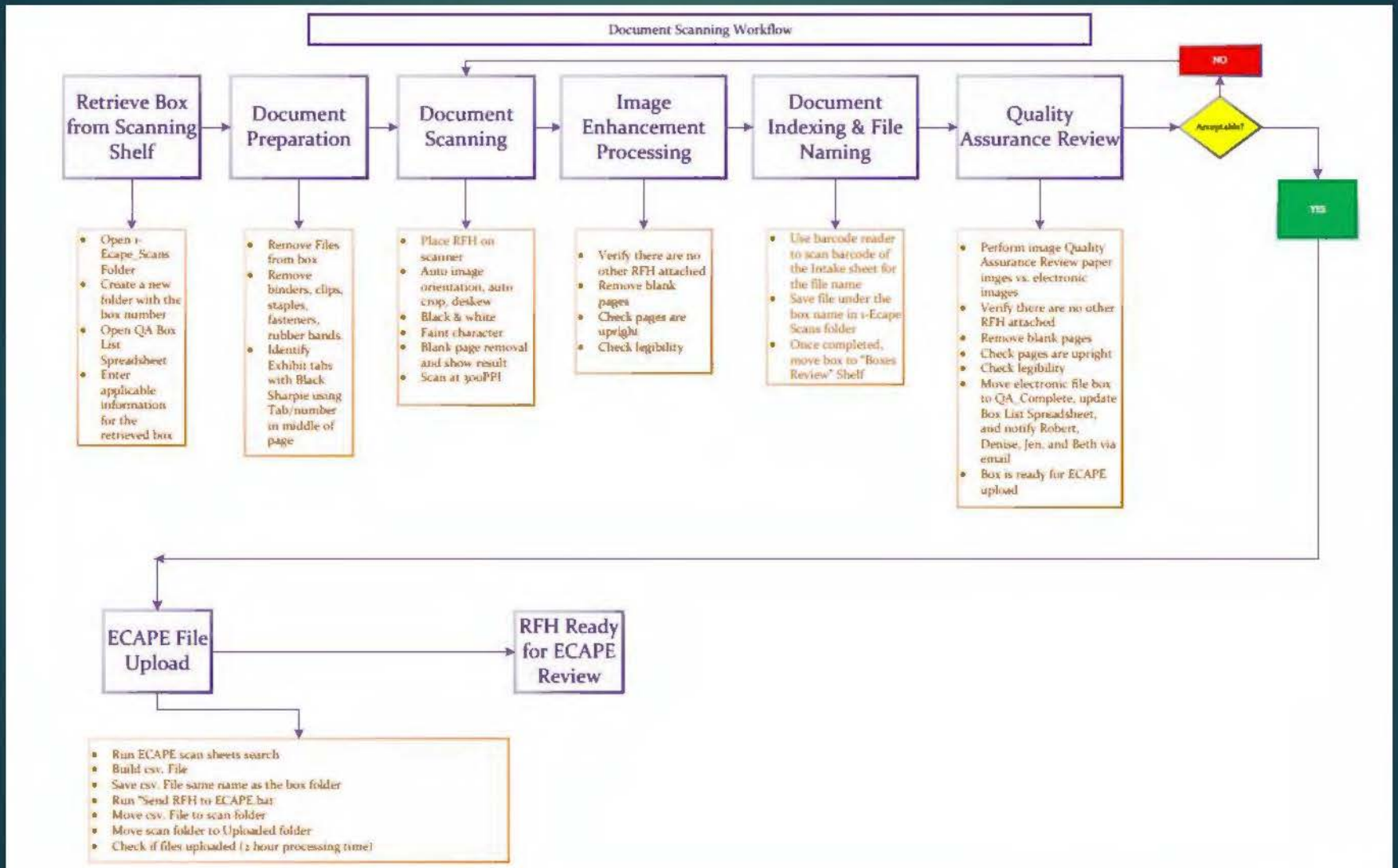
Showing 1 to 6 of 6 entries

Previous

ECAPE Problem Resolution Queue: intake, promotion and other barriers to case processing to be resolved.


Workload Receipt Workflow
RECEIPT
Intake Prep
Intake
Acceptable?
YES
NO
Appeal Created
Promotion
Acceptable?
YES
NO
Scanning
Problem Resolution Team/Problem Resolution Cue

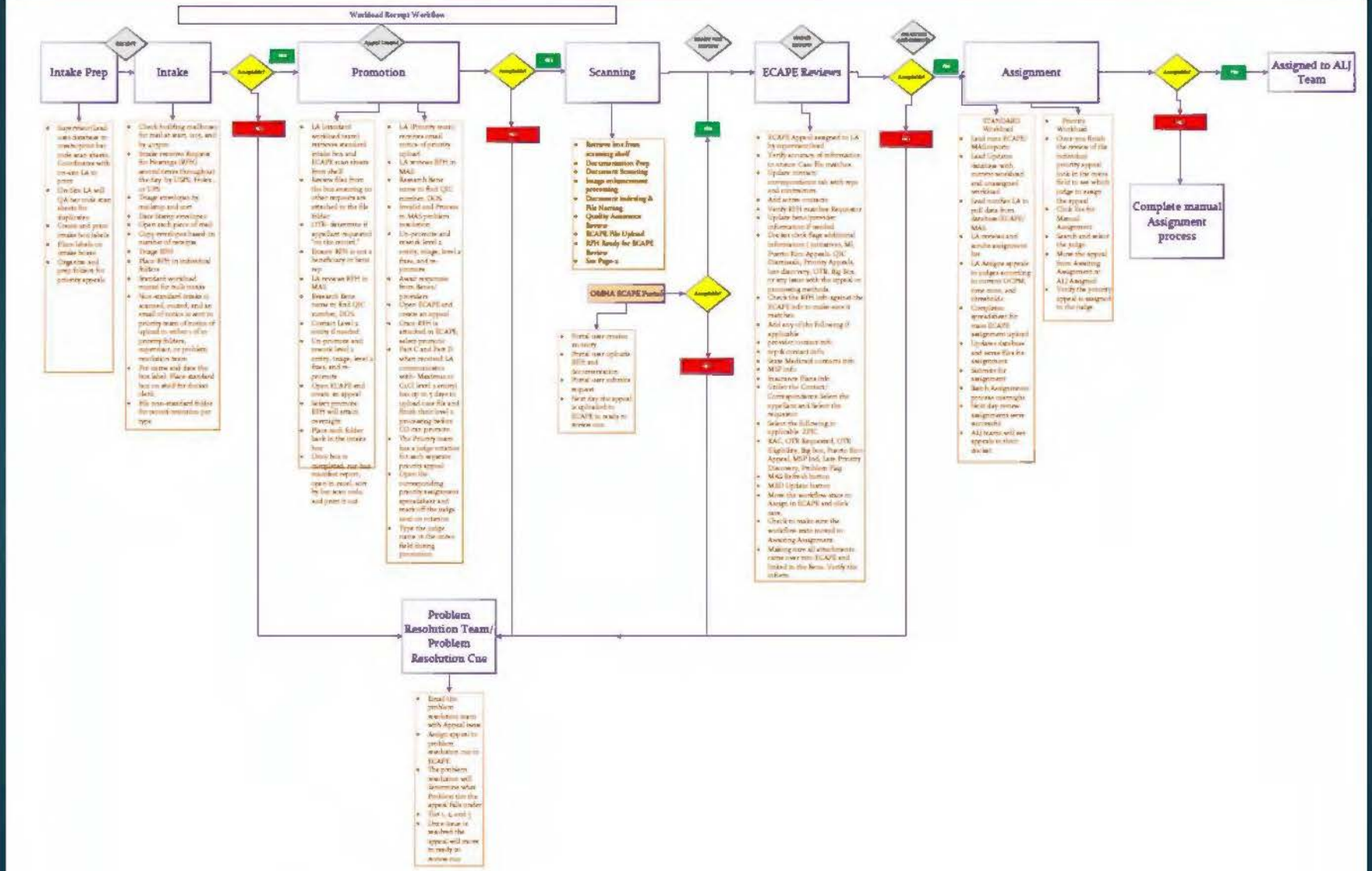
Mass-Production Scanning

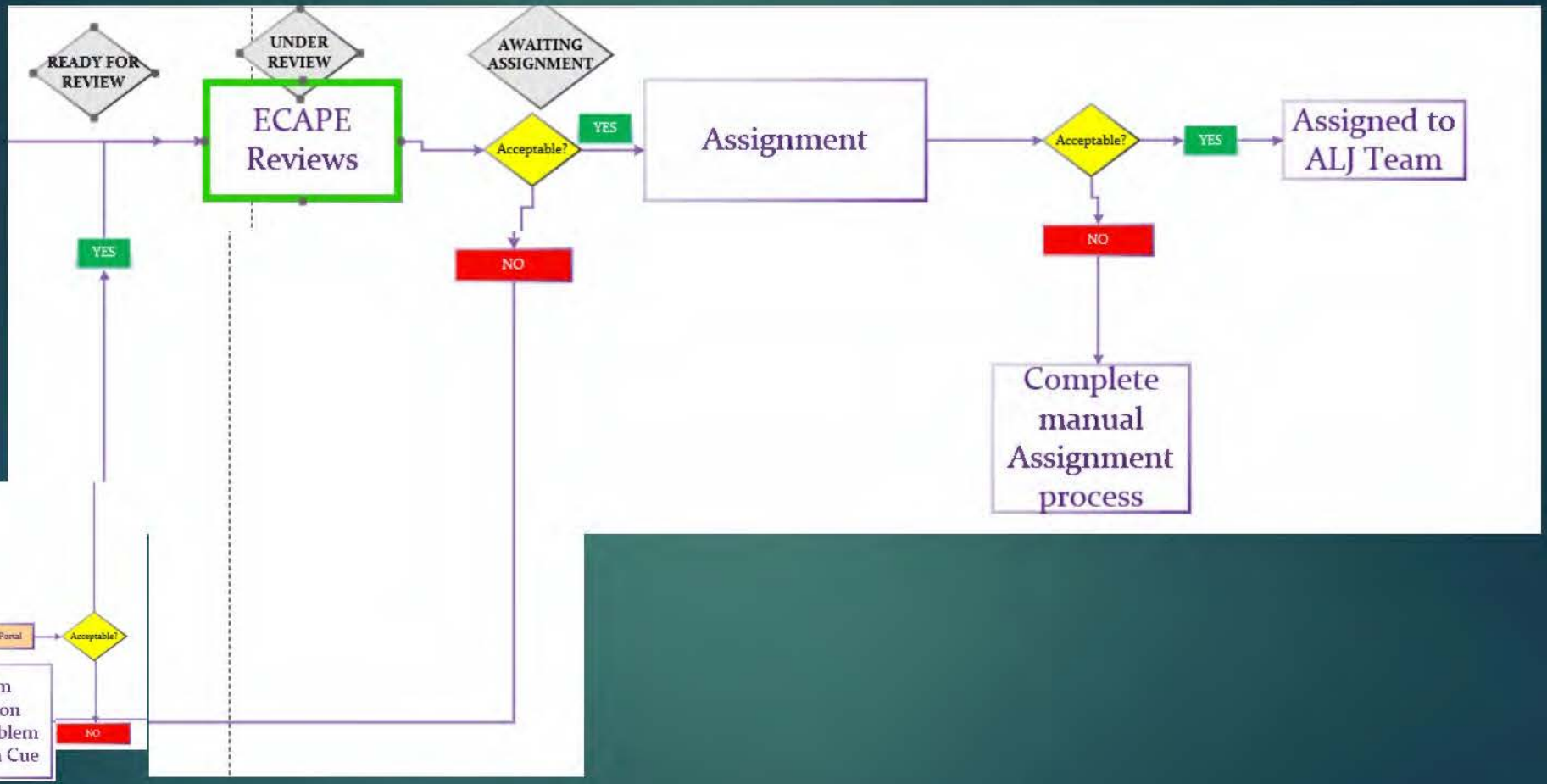


Mass Production Scanning

- Files scanned based on box numbers using bar codes
- Complete the preparation and quality control for high-reliability document scanning.
- Scan all Requests For Hearing and supplemental materials.
- Complete quality control (QC) of scanned images.
- Run batch reports through secure FTP.
- Files are pulled from batch reports and uploaded to ECAPE.
- Scan on average 85,000 images per month.

Overview of Receipt to Assignment Workflow



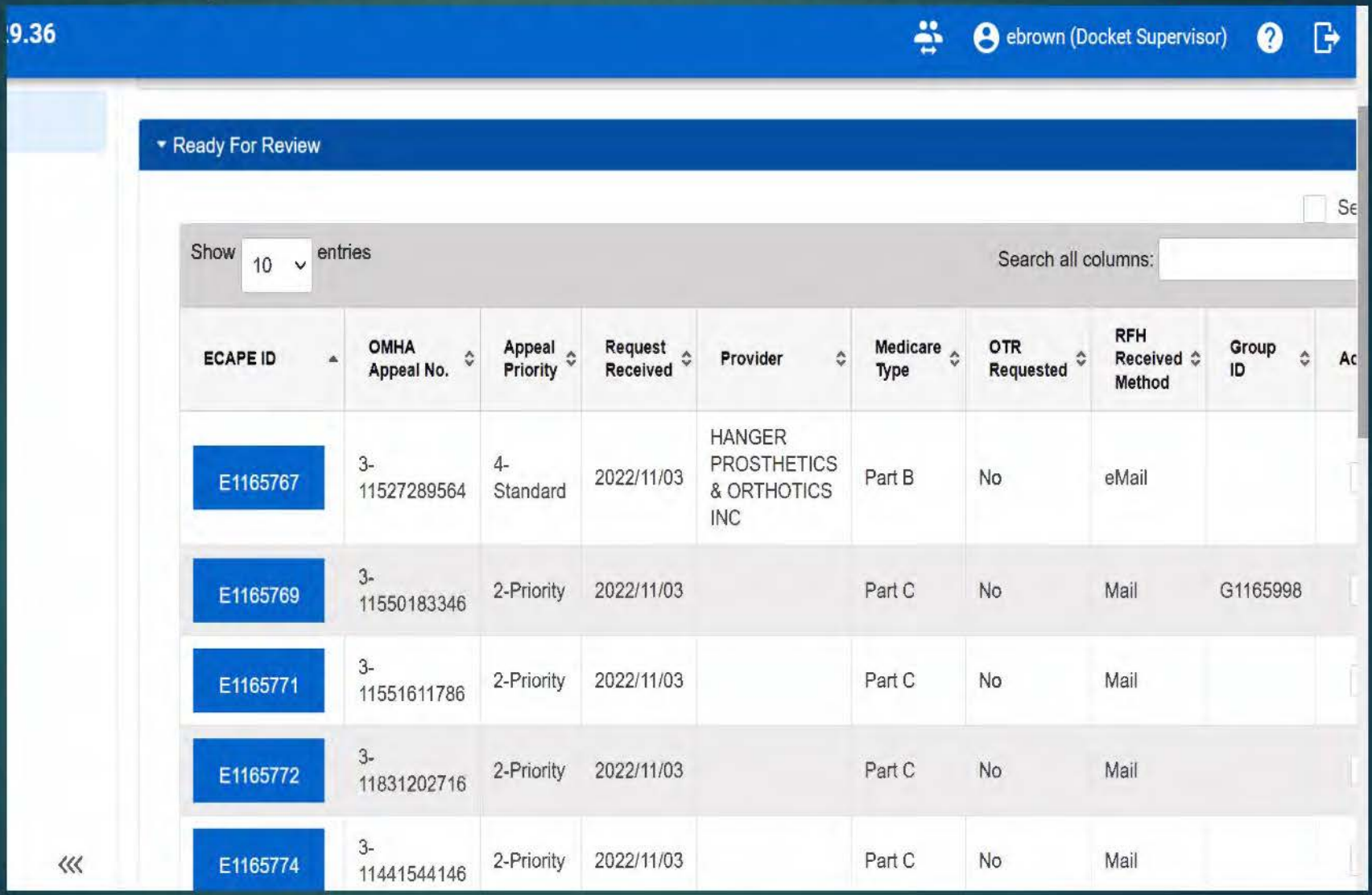

READY FOR REVIEW
UNDER REVIEW
ECAPE Reviews
AWAITING ASSIGNMENT
Acceptable?
YES
Assignment
Acceptable?
YES
Assigned to ALJ Team
NO
YES
NO
Complete manual Assignment process
OMHA ECAPE Portal
Acceptable?
Problem
Resolution
m/Problem
olution Cue
NO

Ready for Review

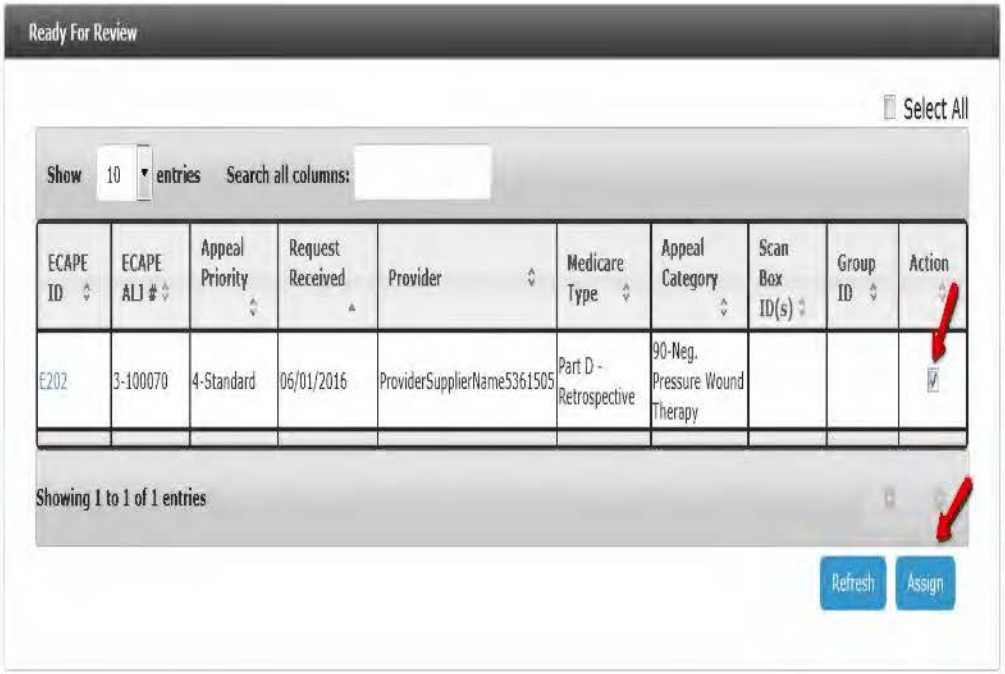
MAIL: Once the scans are attached overnight, the appeal is routed to the "Ready to Review" Queue accessible by CO Supervisors. Supervisors then assign the appeals to LAs to perform ECAPE reviews on the appeal.

PORTAL: This is stage is where portal requests for hearing first appear in our case processing.

Ready for Review Queue

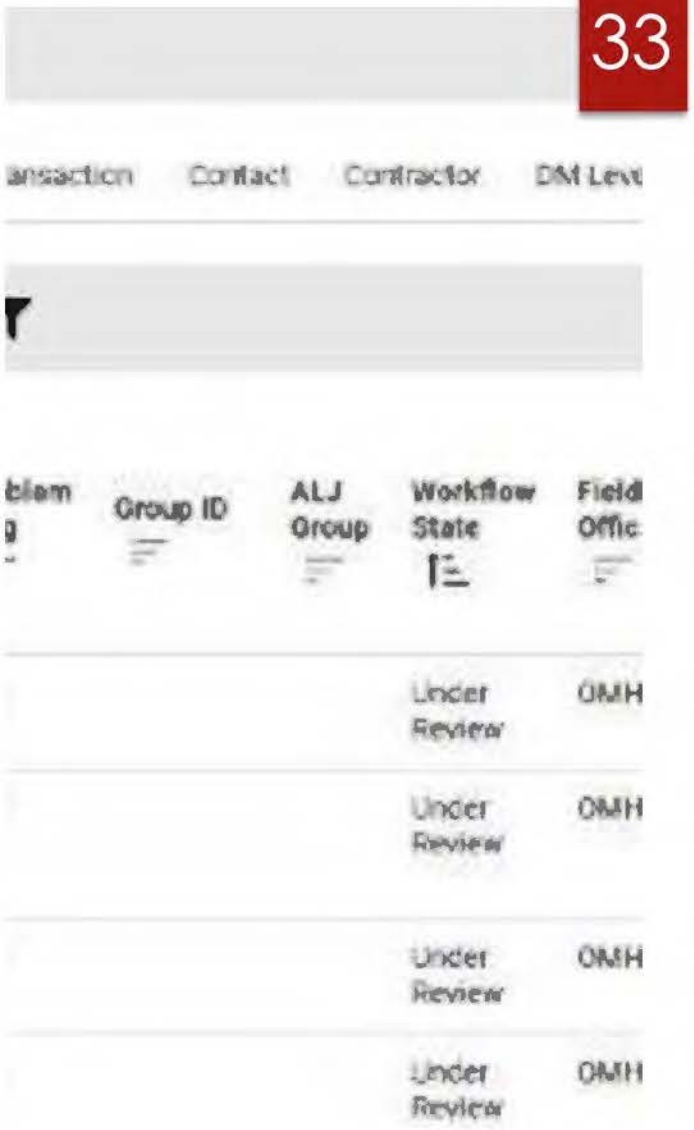


Assigning Appeals to be Reviewed

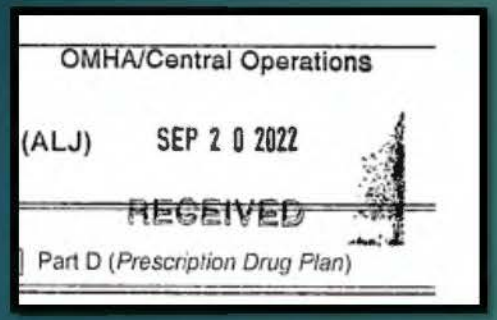


After appeal promotion and the RFH file has been scanned and attached to the appeal, Docket Supervisors can review appeals and assign them to a Docket Clerk for review from this queue. The assigned appeals land in the assigned LA's queue.

Once assigned, the appeals are sorted by the LA by request received date and reviewed. Appeals are reviewed by looking at the RFH and supplemental submissions, entering information, verifying information and flagging problems.



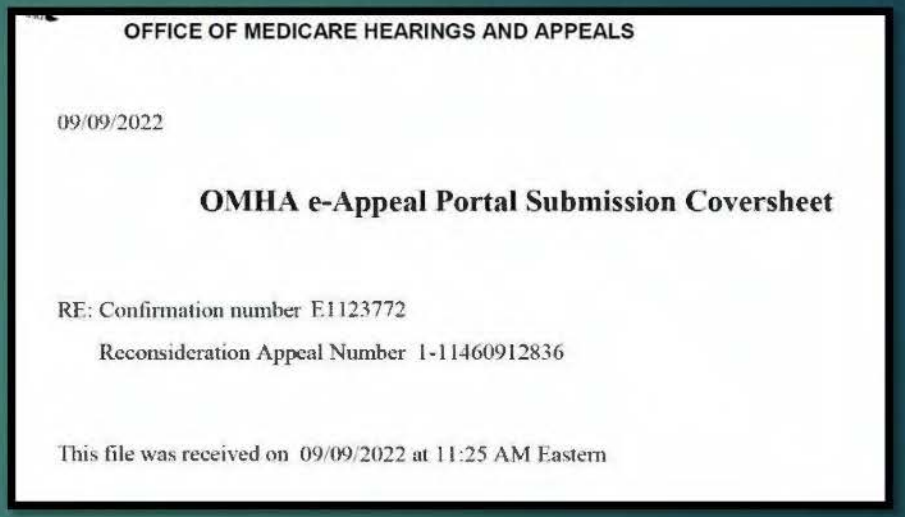
RFHs are reviewed and information entered into ECAPE


OMHA/Central Operations

(ALJ) SEP 2 0 2022

RECEIVED

Part D (*Prescription Drug Plan*)


OFFICE OF MEDICARE HEARINGS AND APPEALS

09/09/2022

OMHA e-Appeal Portal Submission Coversheet

RE: Confirmation number E1123772

Reconsideration Appeal Number 1-11460912836

This file was received on 09/09/2022 at 11:25 AM Eastern

Appeal Reviews

Using attached RFH and other submissions, Legal Assistant checks and enters the following:

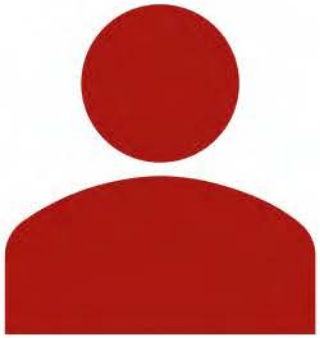
- Reconsideration number promoted is accurate for the appeal.

- Initial and complete RFH date.

- Contacts and correspondence entries; addresses; new contacts or providers; active contact; contractors.

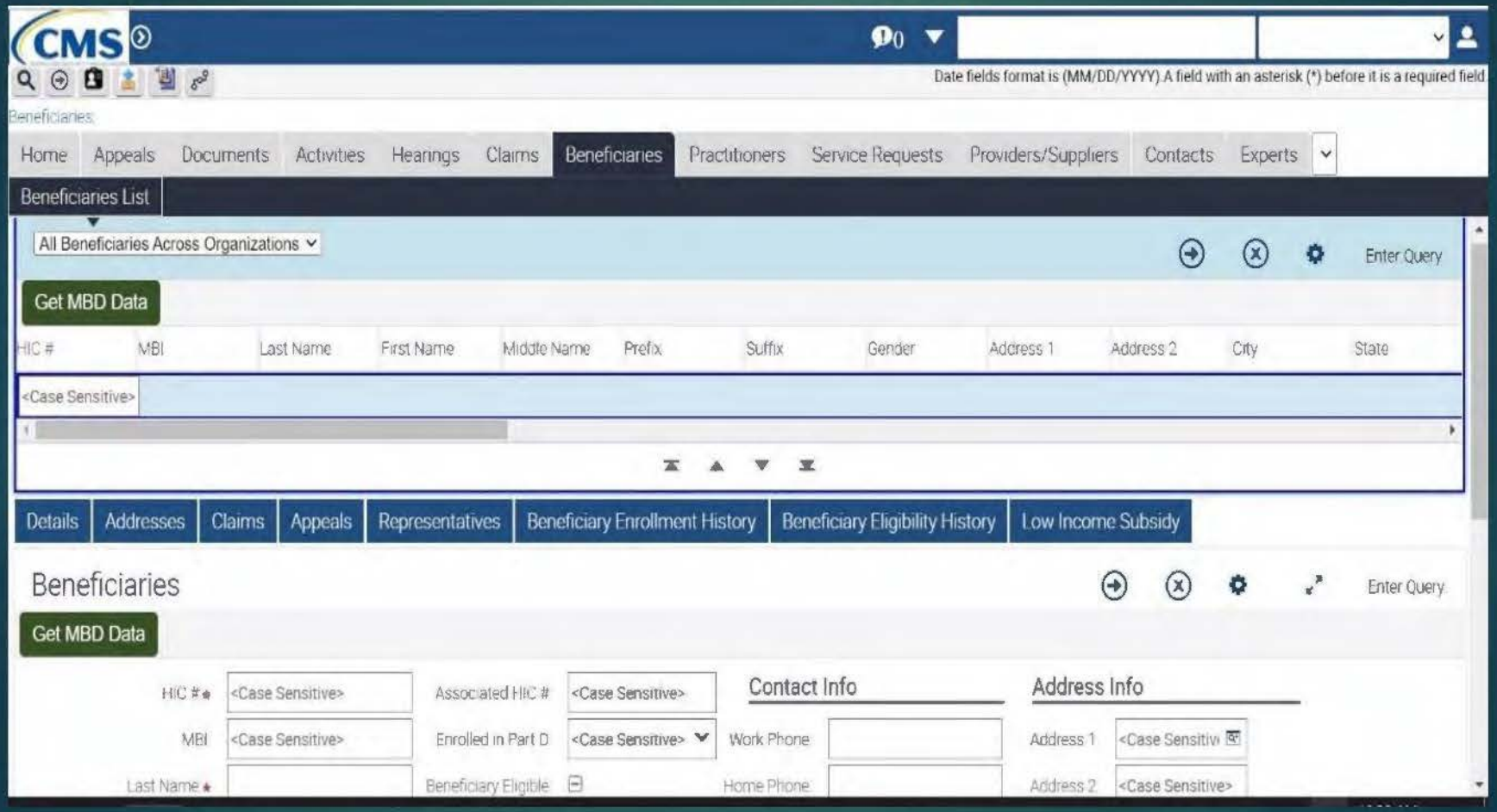
- Checks RFH against L2 claim, DOS and beneficiary data.

- Specifics about the appeal required for rotations, MI, or ECAPE.

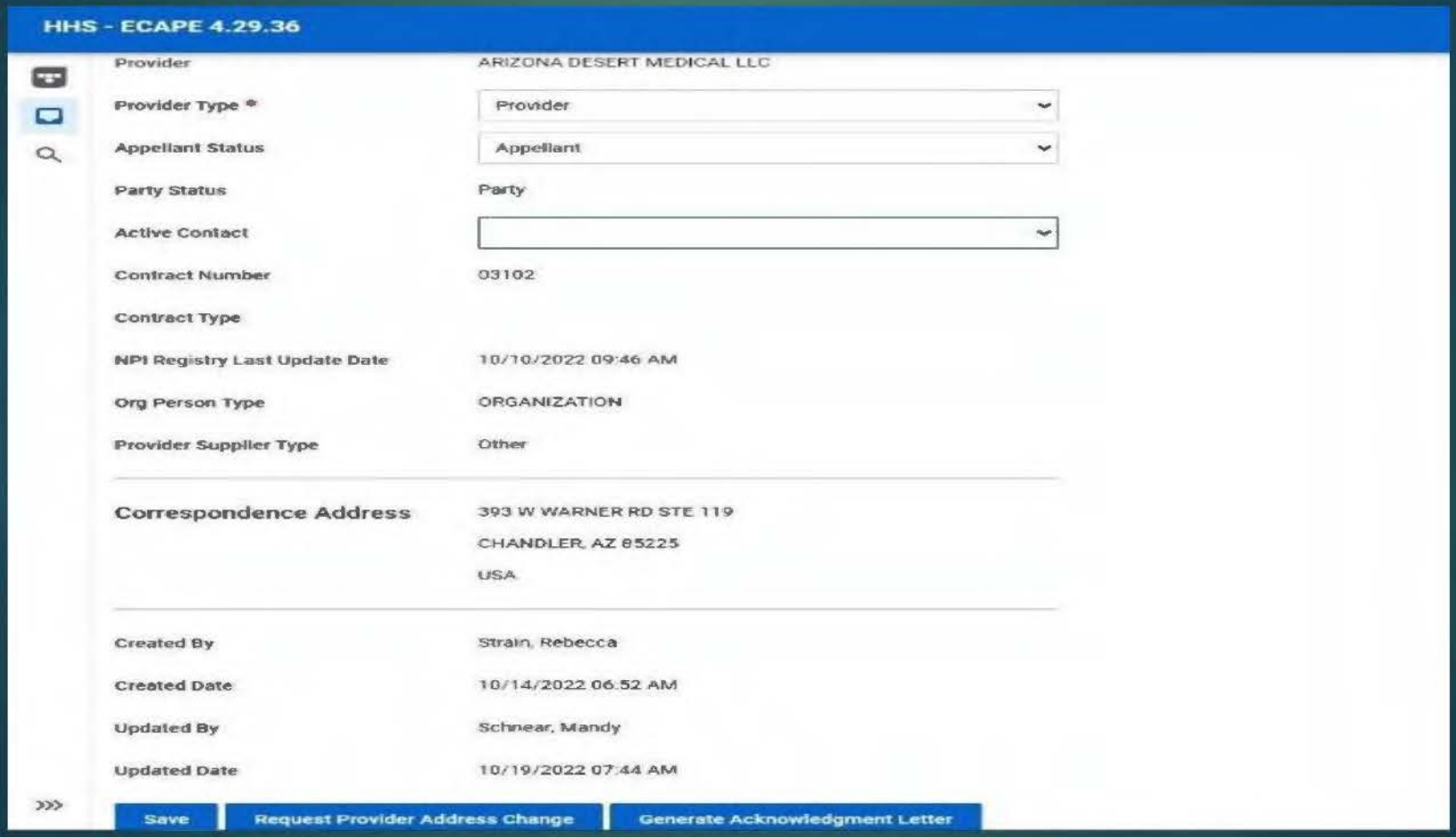


Verify/add/change contacts and correspondence. Select active contact, add rep. Verify addresses, send requests for changes to repository HQ Users for approval.

Beneficiary/parties updated



Party status updated



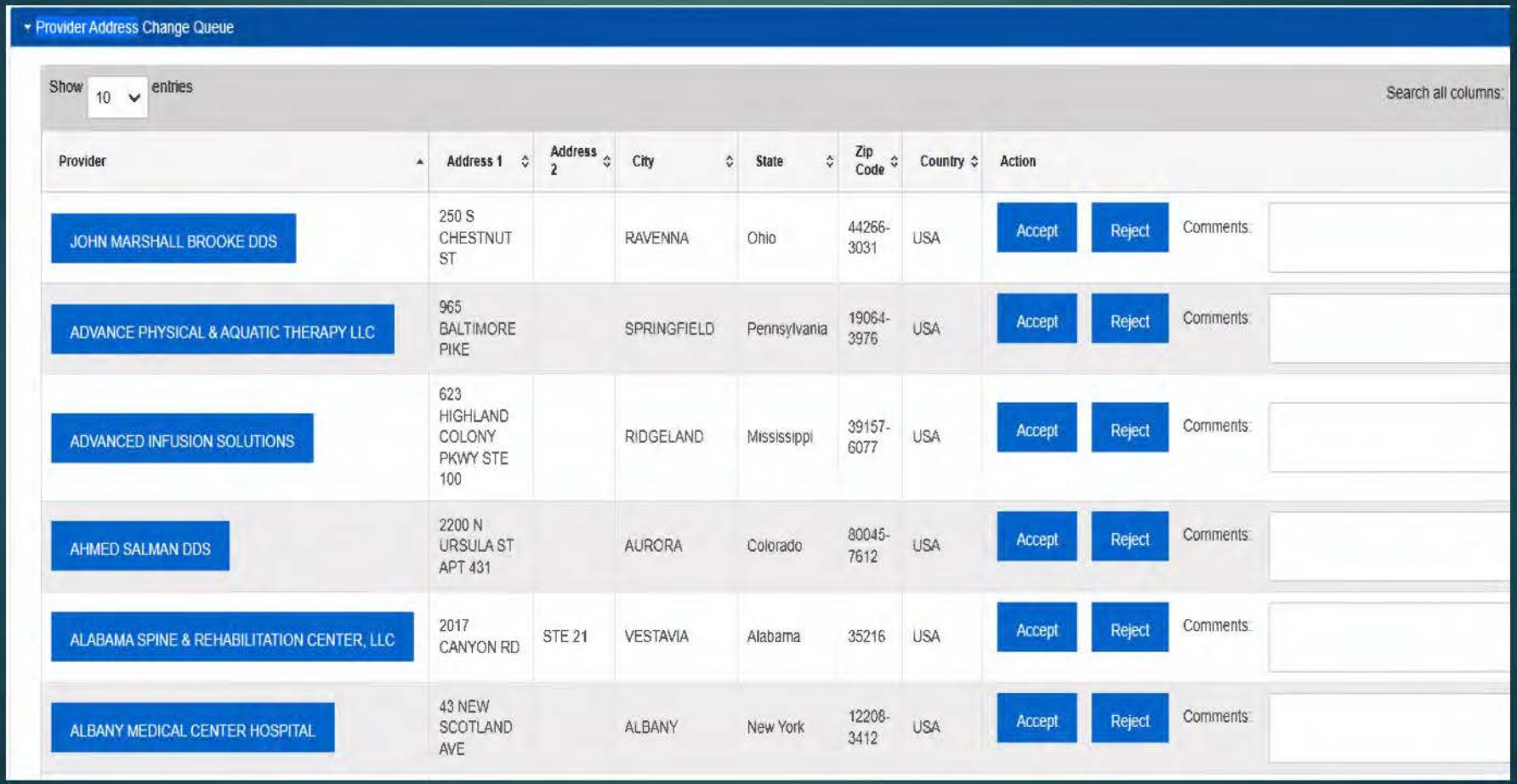
New parties, reps, contractors, addresses

- CO adds:

- Reps and their address
- Contractors and their address
- Parties and their address

- CO HQ Users approve these entries in the ECAPE repositories before an appeal is assigned to an ALJ of adjudicator

Provider Queue Repository



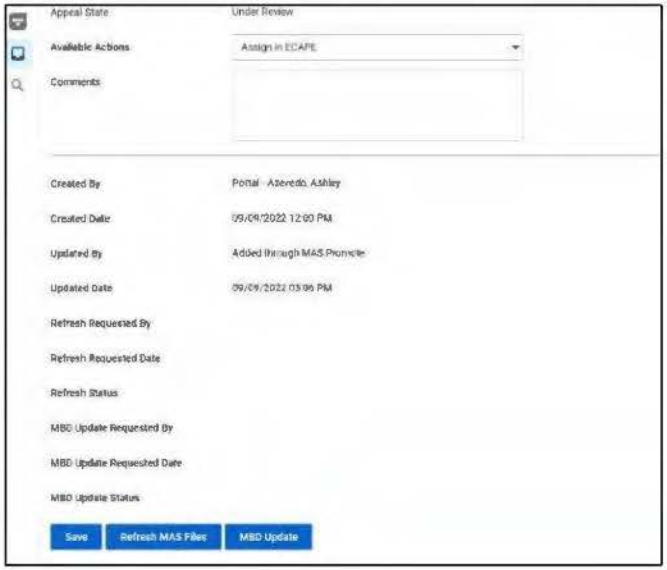
Provider Address Change Queue

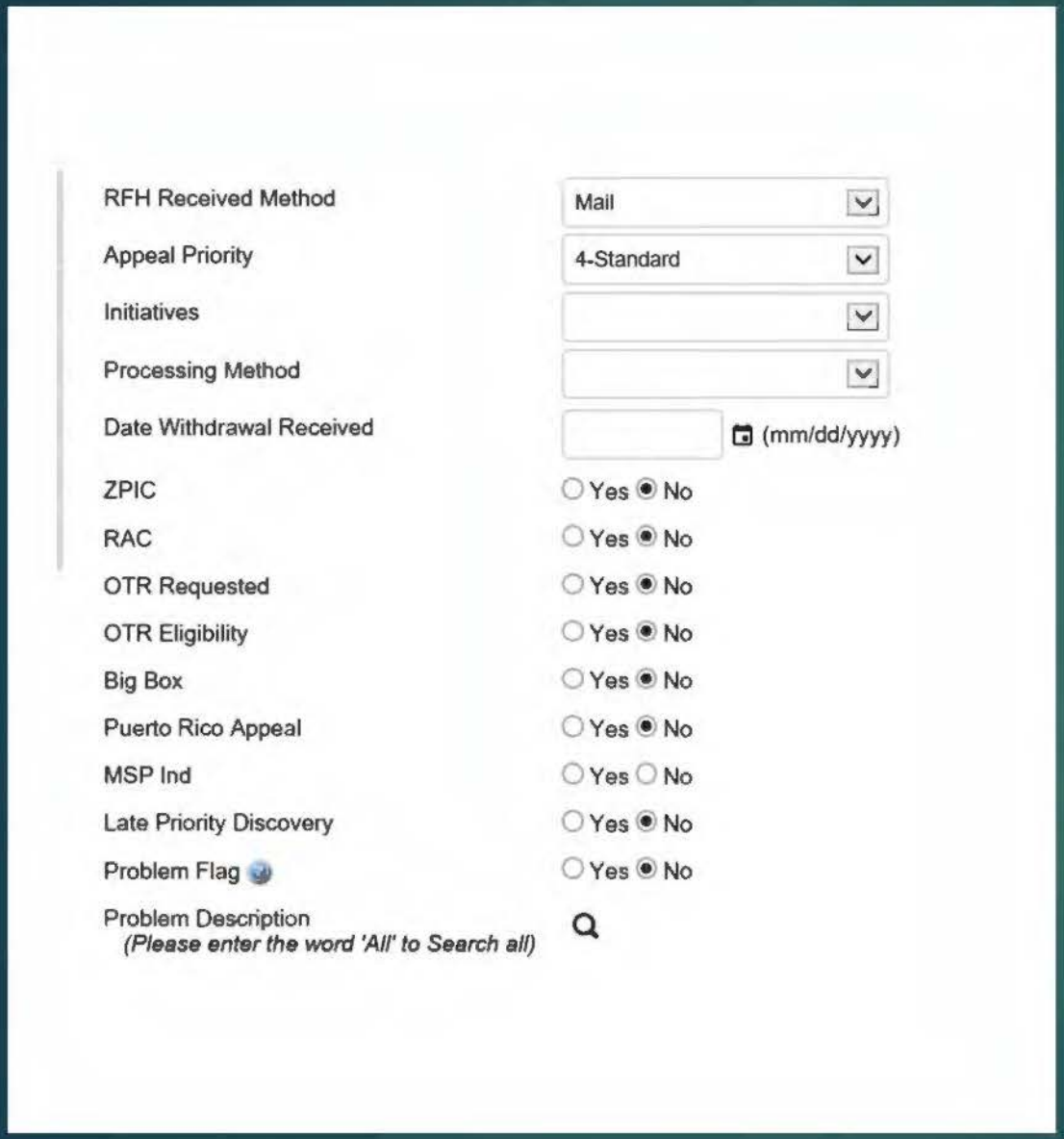
Show 10 entries

Search all columns:

Provider	Address 1	Address 2	City	State	Zip Code	Country	Action
JOHN MARSHALL BROOKE DDS	250 S CHESTNUT ST		RAVENNA	Ohio	44266-3031	USA	Accept Reject Comments:
ADVANCE PHYSICAL & AQUATIC THERAPY LLC	965 BALTIMORE PIKE		SPRINGFIELD	Pennsylvania	19064-3976	USA	Accept Reject Comments:
ADVANCED INFUSION SOLUTIONS	623 HIGHLAND COLONY PKWY STE 100		RIDGELAND	Mississippi	39157-6077	USA	Accept Reject Comments:
AHMED SALMAN DDS	2200 N URSULA ST APT 431		AURORA	Colorado	80045-7612	USA	Accept Reject Comments:
ALABAMA SPINE & REHABILITATION CENTER, LLC	2017 CANYON RD	STE 21	VESTAVIA	Alabama	35216	USA	Accept Reject Comments:
ALBANY MEDICAL CENTER HOSPITAL	43 NEW SCOTLAND AVE		ALBANY	New York	12208-3412	USA	Accept Reject Comments:

Request MAS files and MBD update and move to awaiting assignment





Important data reviewed and entered for rotations, MI and initiatives

Awaiting Assignment

- Once LA finishes reviewing the appeal and there are no issues requiring problem resolution, the LA moves the appeal to "Awaiting Assignment."
- CO builds lists of assignable appeals utilizing this queue but relies on an outside database to build the lists based on docket thresholds and other factors.

Assignments

- Standard Assignments:

- currently a two-three day process

- first step: run docket numbers to determine needs and capacity;

- Second step: search available appeals ready to be assigned through database; identify groups and same benes, build assignment list and enter assignments (runs by batch overnight)

- Separate rotations for AAP and big box appeals.

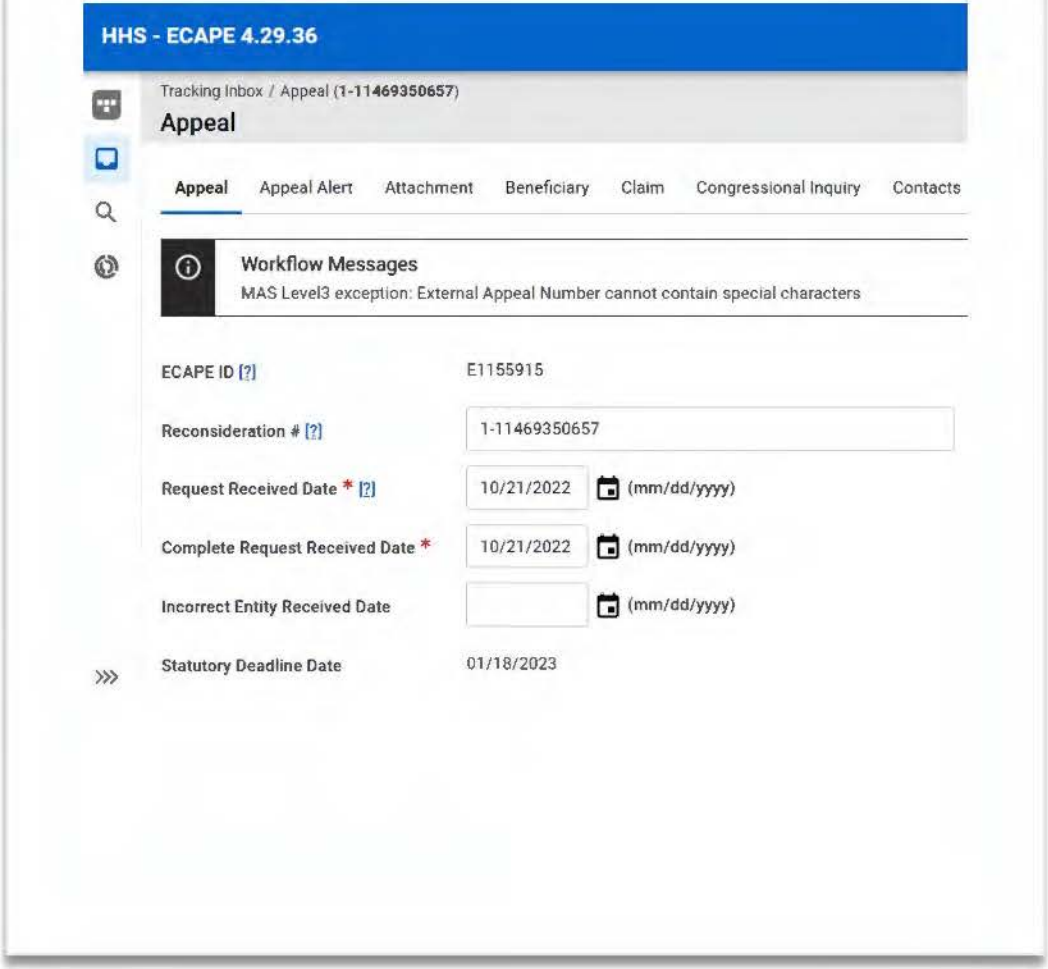
Note: all priority 1 and 2 appeals follow a different process.

Roadblocks

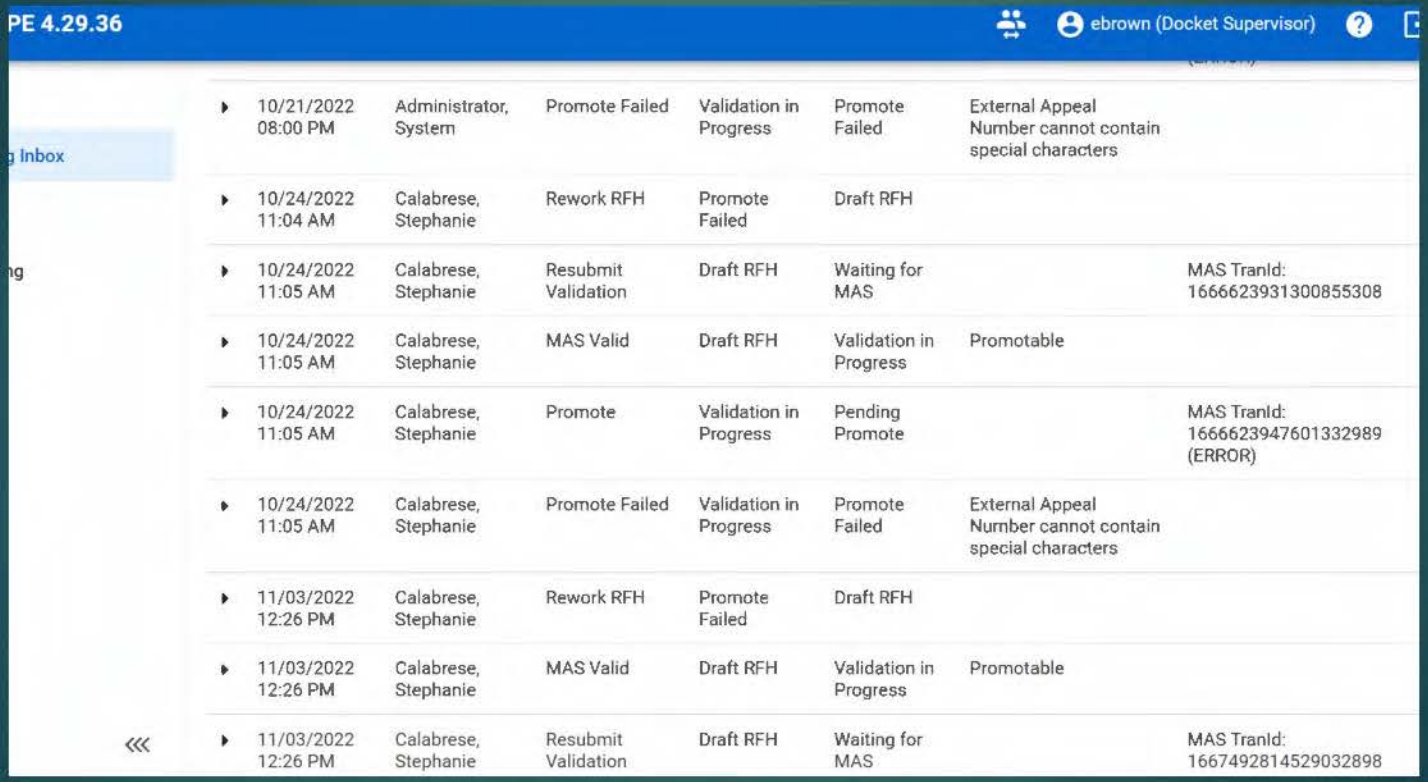
- Systems Issues (ECAPE or MAS) usually caused by appellant submissions errors;
- Level 2 and Level 4 coordination issues;
- Unexpected events (office closings, COOP)
- Unusual increases in receipts
- Timing (appeal submitted on Friday afternoon in the portal before a holiday weekend);
- Portal submissions that should not be submitted in the portal.

Example: Systems Issues

ECAPE Portal submission with an error, fails promotion and ends up in CO's ECAPE Problem Resolution Queue to resolve.

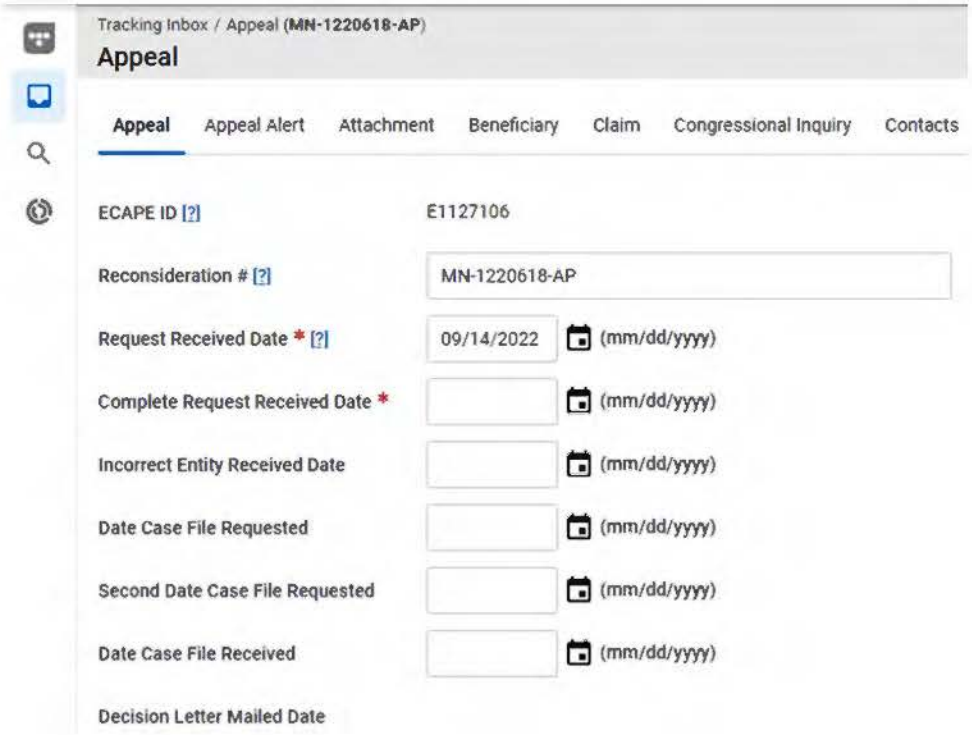


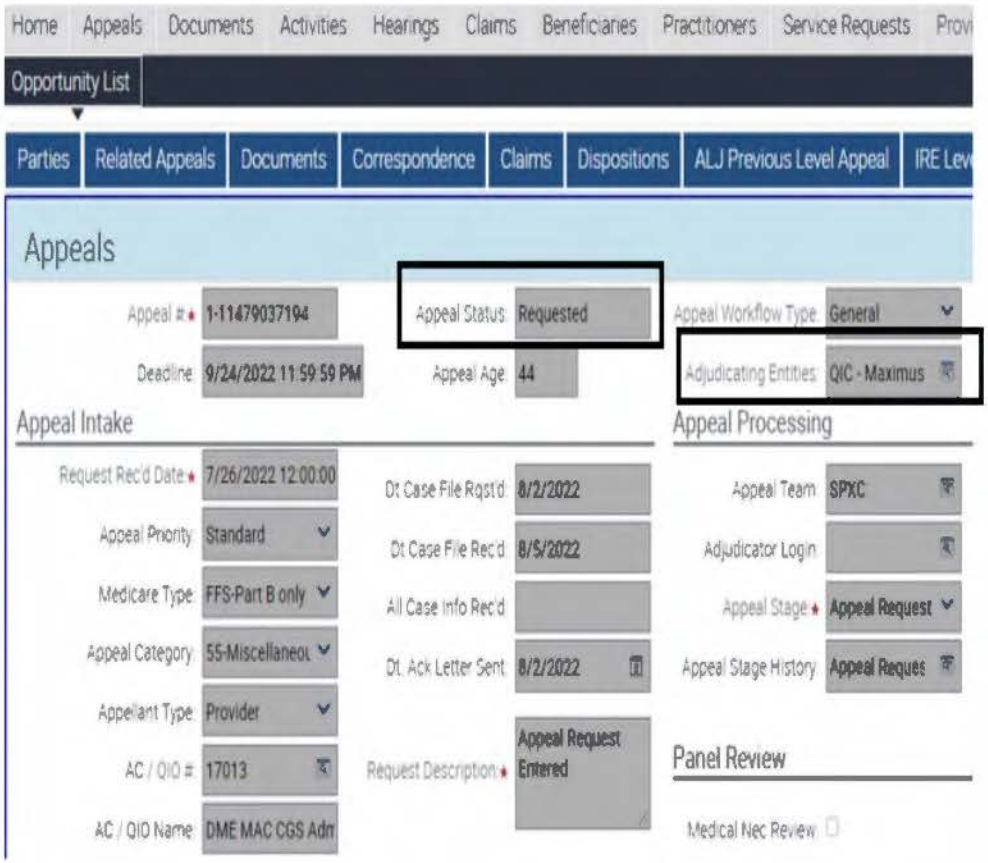
Example of delays in promotion



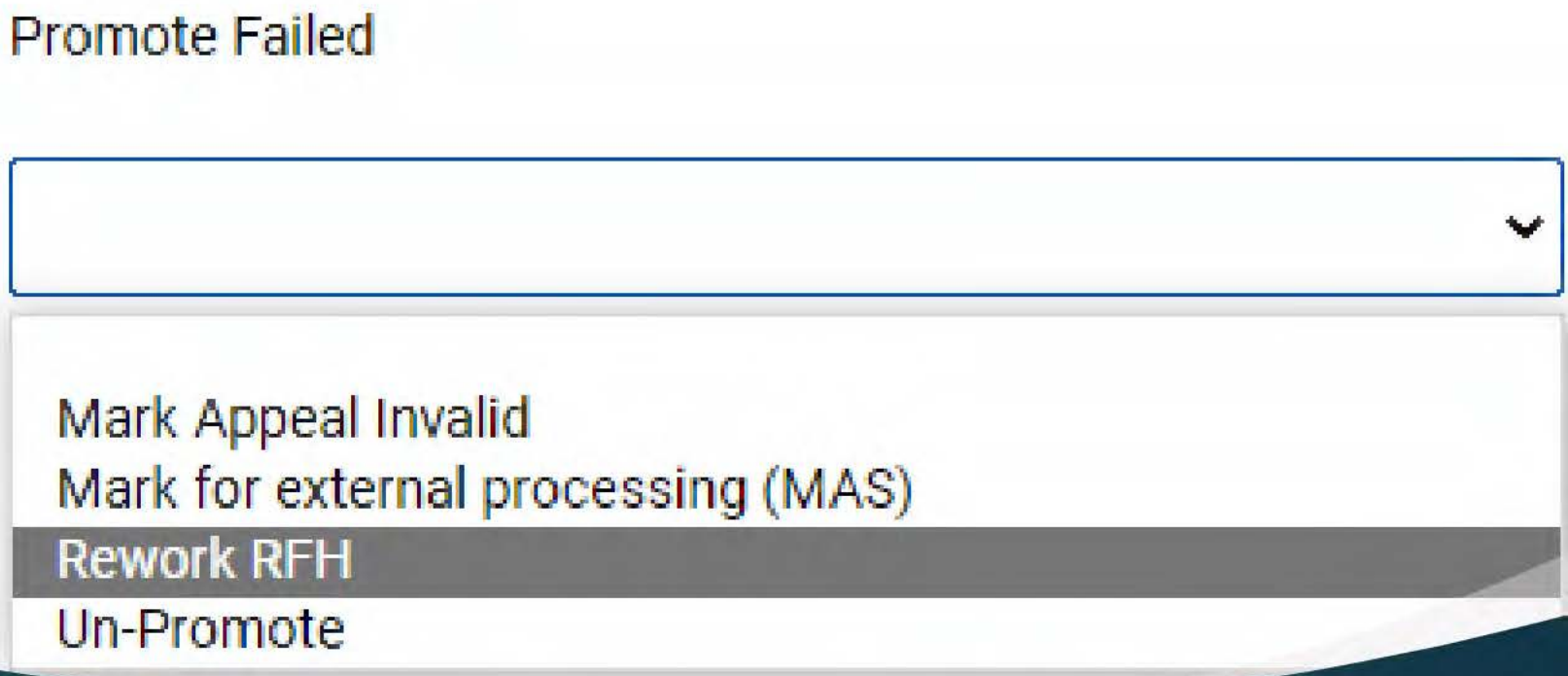
▸	10/21/2022 08:00 PM	Administrator, System	Promote Failed	Validation in Progress	Promote Failed	External Appeal Number cannot contain special characters	
▸	10/24/2022 11:04 AM	Calabrese, Stephanie	Rework RFH	Promote Failed	Draft RFH		
▸	10/24/2022 11:05 AM	Calabrese, Stephanie	Resubmit Validation	Draft RFH	Waiting for MAS		MAS TranId: 1666623931300855308
▸	10/24/2022 11:05 AM	Calabrese, Stephanie	MAS Valid	Draft RFH	Validation in Progress	Promotable	
▸	10/24/2022 11:05 AM	Calabrese, Stephanie	Promote	Validation in Progress	Pending Promote		MAS TranId: 1666623947601332989 (ERROR)
▸	10/24/2022 11:05 AM	Calabrese, Stephanie	Promote Failed	Validation in Progress	Promote Failed	External Appeal Number cannot contain special characters	
▸	11/03/2022 12:26 PM	Calabrese, Stephanie	Rework RFH	Promote Failed	Draft RFH		
▸	11/03/2022 12:26 PM	Calabrese, Stephanie	MAS Valid	Draft RFH	Validation in Progress	Promotable	
▸	11/03/2022 12:26 PM	Calabrese, Stephanie	Resubmit Validation	Draft RFH	Waiting for MAS		MAS TranId: 1667492814529032898

Portal Submission Issues





Level 2 and Level 4 coordination issues. Example: Appeal is not closed at level 2 and therefore, cannot be promoted.

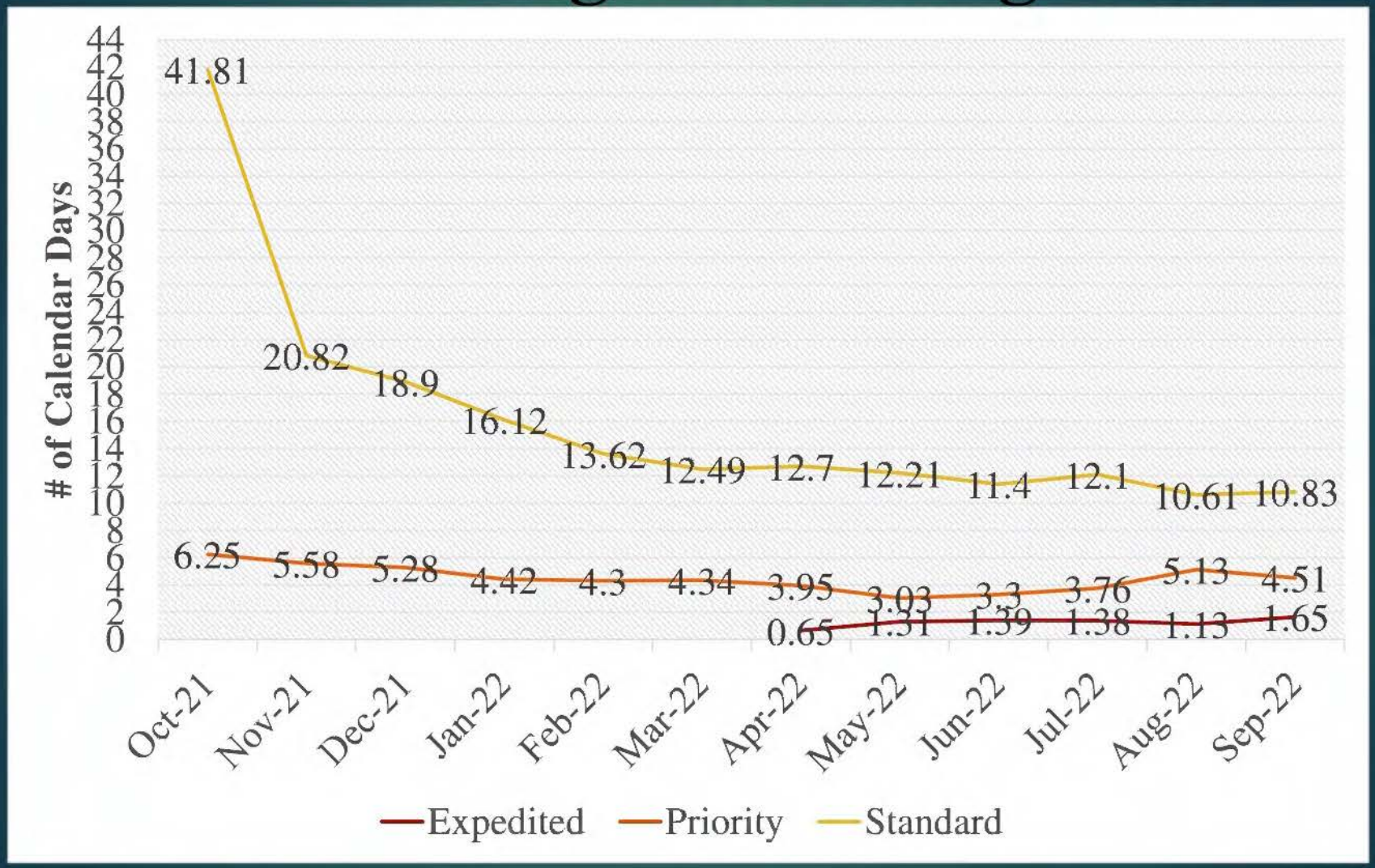


Appeals open at Level 2 fail promotion and require CO to reach out to the QIC, have them close the appeal and then rework the RFH.

CO marks QIOs invalid and has to start the appeal as a manual appeal.

Non-promotable appeals and beneficiary appeals

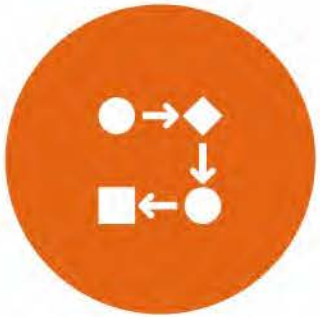
FY 22 Receipt to Assignment Average Processing Time



FY 20 to FY 22 Comparison Standard Appeal Workload RFH ->Assignment

QAI	RFH -> Assigned	Central Ops	RFH -> Assigned	Central Ops	RFH -> Assigned
FY20 Q1	315.52	**FY21 Q1**	68.35	**FY22 Q1**	27.18
FY20 Q2	236.97	**FY21 Q2**	48.7	**FY22 Q2**	14.08
FY20 Q3	199.02	**FY21 Q3**	44.02	**FY22 Q3**	12.10
FY20 Q4	133.52	**FY21 Q4**	42.97	**FY22 Q4**	11.18

What's Next?



CONTINUE TO STUDY WORKFLOW TO FIND PROCESSING TIME IMPROVEMENTS;

CONTINUE TO WORK WITH INTERNAL AND EXTERNAL PARTNERS TO LOOK FOR SYSTEMS IMPROVEMENTS OR APPEAL COORDINATION IMPROVEMENTS;

REFINE APPEAL ASSIGNMENTS TO BEST SUPPORT THE ALJ TEAMS AND ADJUDICATORS.

90 DAY ADJUDICATION TRAINING: Part 2

Pre-Scheduling Review and Workflow Efficiencies

Items to Identify Early During Pre-Scheduling Review (PSR)

- Oral Hearing Waivers (OTR Requests)
- Adjudication Time Frame Waiver (Deadline Waiver)
- Request for Hearing Deficiencies
  - Content
  - Timeliness
  - Copy Requirement
- Appointment of Representative Deficiencies

What is the Benefit of Identifying Early

- Saving on Processing Time
- Workload Prioritization
- Events that Affect the 90 day Timeline

Oral Hearing Waivers (OTR Requests)

- May be waived by the Appellant or other parties who are sent the Notice of Hearing (NOH)
- May not be solicited

  See OCPM Ch. 14 § 14.2.4

What Form Can the Oral Hearing Waiver Take

- Request For Hearing (RFH) form, section 9
- OMHA-104 Form (Waiver of Right to Administrative Law Judge Hearing)
- Response to Notice of Hearing form, section 4
- Any other writing from the Appellant

Identifying Oral Hearing Waivers at Filing (OTR Requests)

- Appellant written statement anywhere within the RFH
- Section 9 of the RFH (Form OMHA-100):

Section 9: Is there other information about your appeal that we should know?		
Are you aggregating claims to meet the amount in controversy requirement? (*If yes, attach your aggregation request. See 42 C.F.R. § 405.1006(e) and (f), and 423.1970(c) for request requirements.*)	☐ No	☐ Yes
Are you waiving the oral hearing before an ALJ and requesting a decision based on the record? (*If yes, attach a completed form OMHA-104 or other explanation. N/A if requesting review of a dismissal.*)	☐ No	☐ Yes
Does the request involve claims that were part of a statistical sample? (*If yes, please explain the status of any appeals for claims in the sample that are not included in this request.*)	☐ No	☐ Yes

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

WAIVER OF RIGHT TO AN ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

Instructions: If you are an appellant or other party to a hearing before an Administrative Law Judge (ALJ) with the Office of Medicare Hearings and Appeals (OMHA), you may waive your right to the oral hearing and request that a decision be made based on the record. When you waive your right to a hearing, either an ALJ or an attorney adjudicator may decide your appeal.

If you are the appellant and want your appeal to be decided without a hearing, complete this form and include it with your request for an ALJ hearing (form OMHA-100) or, if you have already filed your request for an ALJ hearing, send this form to the assigned OMHA adjudicator (visit www.hhs.gov/omha and use the appeal status lookup tool to find your assigned adjudicator). Any other party that wants the appeal to be decided without a hearing may complete this form and send it to the assigned OMHA adjudicator. If an adjudicator has not yet been assigned, send this form to OMHA Central Operations, Attention: Waiver Mail Stop (visit www.hhs.gov/omha or call the number at the bottom of this form for the full mailing address).

If all of the parties to the appealed matter who would be sent a notice of hearing do not also waive the ALJ hearing (for example, a provider or supplier that was held financially responsible for the denied items or services), or the assigned ALJ or attorney adjudicator believes a hearing is necessary to decide the appeal, a hearing may be held by an ALJ, and the ALJ will issue the decision or other dispositive order in the appeal.

Section 1: What is the OMHA appeal number or the reconsideration (Medicare appeal or case) number?

OMHA Appeal Number *(if known)*	Reconsideration Number *(if OMHA appeal number not known)*

Section 2: What is the information for the party waiving the hearing? *(Representative information in next section)*

Name *(First, Middle initial, Last)*	Firm or Organization *(if applicable)*	Telephone Number

Section 3: What is the representative's information? *(Skip if you do not have a representative)*

	Firm or Organization *(if applicable)*	Telephone Number

are attending *(attach a continuation sheet if necessary)*:

Section 3 : What is the representative's information? (*Skip if you do not have a representative*)

Name	Firm or Organization (*if applicable*)	Telephone Number	
Mailing Address	City	State	ZIP Code

Section 4: Will you be present at the time and place shown above? (*Check one*)

☐ **I will be present at the time and place shown on the notice of hearing.** If an emergency arises after I submit this response and I cannot be present, I will notify the ALJ at the telephone number shown at the top of the notice of hearing as soon as possible.

☐ **I cannot be present at the time and place shown on the notice of hearing and would like to request that my hearing be rescheduled.** I understand that the ALJ has the discretion to change the time and place of the hearing as long as my explanation for my request to reschedule meets the good cause standard for changing the time and place of the hearing. (For example, good cause may be found due to an inability to attend the hearing because of a serious physical or mental condition, incapacitating injury, or death in the family or if severe weather conditions make it impossible to travel to the hearing. *See* 42 C.F.R. sections 405.1020(f) and (g), and 42 C.F.R. sections 423.2020(f) and (g) for additional circumstances that may establish good cause.) I understand that if I am the appellant and the hearing is postponed at my request, the time between the originally scheduled hearing date and the new hearing date is not counted toward any applicable adjudication period.

I would like to reschedule my hearing for the following date and time, and I have good cause to reschedule my hearing because:

☐ **I want to waive my right to appear at the ALJ hearing.** (*Please complete form OMHA-104 and attach it to this response.*)

Adjudication Time Frame Waiver (Deadline Waiver)

- A written statement, from the Appellant, indicating that he or she is waiving the adjudication time frame.
- Appellant may use Section 7 on the Response to Notice of Hearing form (OMHA-102).
- Only an Appellant may initiate an adjudication time frame waiver.

See OCPM Ch. 7, § 7.3

How Would A Deadline Waiver Arise During PSR

- A separate Appellant statement attached to the RFH Form
- Note: the RFH Form does not include a waiver box

Identifying Events that Affect the Start of the 90 Day Adjudication Time Frame

- The Appellant's RFH does not satisfy the regulatory content requirements
  42 C.F.R. § 405.1014(b)(1)

- The Appellant files the RFH with an office other than that specified in the reconsideration decision or dismissal - *(Unlikely to Arise During PSR)*
  42 C.F.R. § 405.1014(c)(2)

- The Appellant (other than unrepresented Beneficiary/Enrollee) fails to send a RFH copy to the other parties who were sent the QIC decision.
  42 C.F.R. § 405.1014(d)(1)

- If a RFH is untimely filed and the adjudicator grants an extension to the filing deadline.
  42 C.F.R. § 405.1014(e)(4)

NOTE: These are not TOLLING/DELAY events.

• Beneficiary address	Yes No
• Medicare number	Yes No
• Reconsideration number (Medicare appeal or case number on the first page of the reconsideration or dismissal being appealed)	Yes No
• Date(s) of service at issue	Yes No
• The reason(s) the appellant disagrees with the reconsideration or dismissal	Yes No

Question 7: Does the RFH show that the appellant sent a copy of the RFH to all the parties? Yes No

Pre-Scheduling Review Filing Defect(s)

• Incomplete RFH - Missing Date(s) of service at issue

Pre-Scheduling Review is pending. Response to Notice of Filing Defect not received yet.

Pre-Scheduling Document Date (mm/dd/yyyy)

Generate Pre-Scheduling Document

Pre-Scheduling Document

Addressing RFH Content and Copy Defects

- Appellant, or their Representative, must be notified of the deficiency and provided an opportunity to cure the defect.
- The notice must identify all the procedural defects
- Notice of Filing Defect (OMHA-125)

See OCPM Ch 11, §§ 11.5, 11.6, 11.9

Addressing Untimely RFH Filings

- Evaluate if the Appellant requested a filing extension when the RFH was submitted
- If not, adjudicator determines whether the Appellant is entitled to an opportunity to explain the untimely filing
- Notice of Filing Defect (OMHA-125)

See OCPM Ch 11, §§ 11.4, 11.9

Additional Notice of Filing Defect Notes

- The Notice of Filing Defect must identify all the procedural defects
- Recipient given 20 calendar days to cure defects
- The ALJ or attorney adjudicator makes the final determination whether the defects are cured

See OCPM Ch 11, § 11.9

Effect on the 90 Day Adjudication Timeframe

- Curing RFH Defects Does Not Trigger a Tolling/Delay Event
- These events require an update to the Complete Request Received Date

What Date To Input Into the Complete Request for Hearing Date

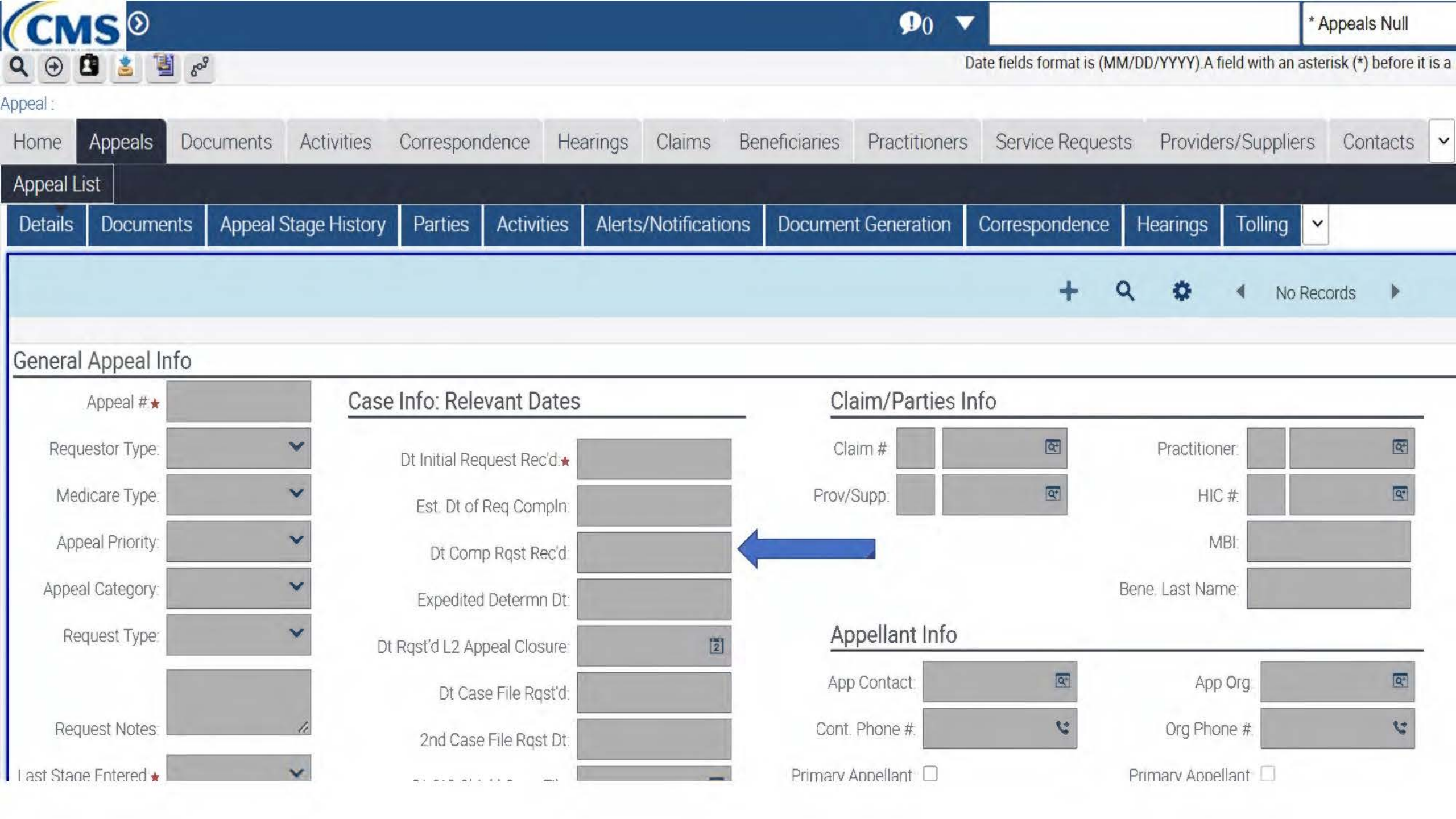
- **If the RFH does not satisfy the regulatory content requirements** → input the receipt date of the completed RFH.

- **If the Appellant (other than unrepresented Bene/Enrollee) fails to send a RFH copy to the other parties** → input the receipt date of evidence that the RFH was properly copied.

- **If the adjudicator finds good cause to extend the filing deadline for an untimely RFH** → input the date the adjudicator grants the filing deadline extension.

Appeal | ALJ Disposition | Appeal Task | Attachment | Beneficiary | Claim | Congressional Inquiry

ECAPE ID	E11366
OMHA Appeal No.	3-100639
Reconsideration #	1-100639
Request Received Date *	05/27/2020
Complete Request Received Date *	05/27/2020 (mm/dd/yyyy)
Incorrect Entity Received Date	(mm/dd/yyyy)
Statutory Deadline Date	08/24/2020
Decision Letter Mailed Date	
Current Age	878
Has Active Tolling Event(s)?	No
Medicare Type	Part A
Appeal Category	Other Surgery
Total Beneficiaries	1
Total Claims	1
Notes	


CMS
0
* Appeals Null
Date fields format is (MM/DD/YYYY).A field with an asterisk (*) before it is a
Appeal :
Home
Appeals
Documents
Activities
Correspondence
Hearings
Claims
Beneficiaries
Practitioners
Service Requests
Providers/Suppliers
Contacts
Appeal List
Details
Documents
Appeal Stage History
Parties
Activities
Alerts/Notifications
Document Generation
Correspondence
Hearings
Tolling
No Records
General Appeal Info
Appeal #
Requestor Type:
Medicare Type:
Appeal Priority:
Appeal Category:
Request Type:
Request Notes:
Last Stage Entered
Case Info: Relevant Dates
Dt Initial Request Rec'd:
Est. Dt of Req Compln:
Dt Comp Rqst Rec'd:
Expedited Determn Dt:
Dt Rqst'd L2 Appeal Closure:
Dt Case File Rqst'd:
2nd Case File Rqst Dt:
Claim/Parties Info
Claim #
Prov/Supp:
Practitioner:
HIC #:
MBI:
Bene. Last Name:
Appellant Info
App Contact:
Cont. Phone #:
Primary Appellant
App Org:
Org Phone #:
Primary Appellant

➢Qualifying Tolling/Delay Events:

- Defective appointment of Representative
- Request for information from Level 2
- A party submits written evidence later than 10 days after receiving the notice of hearing
- The appellant waived right to appear at the hearing and subsequently withdrew waiver
- The hearing is rescheduled at the request of the appellant
- The ALJ continues the hearing at the request of the Appellant
- The appellant waived the adjudication period for a specific time agreed to by the ALJ and appellant
- A party requests discovery from another party to the ALJ hearing
- A party requests a copy of all or part of the record and an opportunity to comment on the record
- A federal court stays the proceedings
- Stay by appellant request

See OCPM Ch. 7, § 7.2.2.

Required Appointment of Representative Elements

- Must be in writing
- Must be signed by the party and the representative
- Must be dated by the party and the representative
- Must provide a statement appointing the representative to act on the party's behalf
- Must include an explanation of the purpose and scope of representation
- Must contain the name, address, and phone number of the party and of the representative
- For Beneficiaries - Must contain the beneficiary's Medicare number (MBI) and authorize the adjudicator to release individually identifiable health information to the representative
- For Provider or Supplier – Must contain the provider or supplier's National Provider Identifier (NPI) number
- Must include the appointed representative's professional status or relationship to the party
- Must be filed with the entity processing the party's initial determinization or appeal

See 42 C.F.R. § 405.910. *See also* OCPM Ch 5, § 5.2.

Addressing Invalid Appointment of Representative

- The party named on the RFH must be given an opportunity to cure the filing defect(s).
- Issue Notice of Filing Defect (OMHA-125) to the party named on the request for hearing.
- Issue a redacted copy of the Notice of Filing Defect to the prospective representative.

See OCPM Ch 5, §§ 5.2.5, 5.2.7.

Notice of Filing Defect Contents

- Describe the missing documentation or information needed for a valid appointment
- Explain that the prospective representative lacks the authority to represent or act on behalf of the party and is not entitled to receive information related to the appeal
- Provides 20 calendar days to cure or otherwise affirm that the party will be unrepresented
- If RFH was filed by the prospective representative ➔ explain that the RFH will be dismissed if no response to the cure letter is received because the RFH filer was not a party and not authorized to submit a RFH.
- If the RFH was filed by the party ➔ explain that all further correspondence will be directed to the party only if no response to the cure letter is received.

See OCPM Ch 5, § 5.2.7.

Effect on the 90 Day Adjudication Time Frame

- Curing Appointment of Representative Defects Triggers a Tolling/Delay Event

How is the Tolling/Delay Event Calculated

- Tolling event **begins** from whichever of the following events is later:

  1) the date that a defective Appointment of Representative was filed, or

  2) the date the appeal request was filed by the prospective appointed representative

- Tolling event **ends** on the date the defect is cured or on the date the party provides notification that they will proceed without representation.

See 42 C.F.R. § 405.910

Requesting Missing Information (RFI) from the CMS contractor, a Plan or SSA.

- Must be in writing (See e.g. OMHA-135)
- Must include:
  - Specific information being requested and why it can only be provided by CMS
  - Applicable timeframe for CMS to furnish the requested information
  - If the missing info is a copy of redetermination or reconsideration decisions, a statement that appeal may be remanded if information is not provided
- May be mailed, faxed, emailed, or sent in accordance with any other OMHA-approved procedures.

How Long Does the Entity Have to Respond

- Fifteen calendar days after receiving the request for information

Effect on the 90 Day Adjudication Time Frame

- The Request for Information process triggers a Tolling/Delay Event

How is the Tolling/Delay Event Calculated

- Tolling/Delay event beings on the date of the RFI
- Tolling/Delay event ends whichever of the following events is earlier:

    1) The date the entity responds; or
    2) 20 calendar days after the date of the RFI

ECAPE
Tolling/Delay Event Entries

ECAPE Tolling/Delay Event Entries

- For a more detailed step by step guide, please see the 2021 “Tolling Events/Delay Events and Alerts” ECAPE Adjudication Desk Guide
- Available through the “Quick Links” queue on your ECAPE home screen.

Adding a Tolling/Delay Event in ECAPE

Appeal | ALJ Disposition | Appeal Task | Attachment | Beneficiary | Claim | Congressional Inquiry | Contacts | Contacts / Correspondence | Contractor | Decision Writing | **Delay Events** | Exhibiting

Delay Event Start Date * (mm/dd/yyyy)

Reason for Delay Event *

Delay Event Alert ◉ Yes ○ No

Notes

Expected End Date * (mm/dd/yyyy)

Expected Days In Delay Event *

Actual End Date (mm/dd/yyyy)

Actual Days in Delay Event

Save

Delay Events

Appeal | ALJ Disposition | Appeal Task | Attachment | Beneficiary | Claim | Congressional Inquiry | Contacts | Contacts / Correspondence | Contractor | Decisior

Delay Event Start Date * 10/27/2022 (mm/dd/yyyy)

Reason for Delay Event *

Delay Event Alert

Notes

- The appellant in a Part A or Part B appeal fails to send a copy of the request for hearing to other parties
- A party submits written evidence later than 10 days after receiving the notice of hearing
- The hearing is rescheduled at the request of the appellant
- Missing material evidence identified by the ALJ at the hearing
- The appellant waived right to appear at the hearing and subsequently withdrew waiver
- The appellant waived the adjudication period for a specific period time agreed to by the ALJ and the appellant
- A party requests discovery from another party to the ALJ hearing
- A party requests a copy of all or part of the record and an opportunity to comment on the record
- A Federal court stays the proceedings
- Stay by Appellant request
- Defective appointment of Representative
- Request for information from Level 2

Expected End Date *

Expected Days In Delay Event *

Actual End Date (mm/dd/yyyy)

Actual Days in Delay Event

Save

NOTE: the highlighted item is Not a Tolling Event. When this issue is cured, it triggers a change to the *Complete Request Received Date*.

The appellant in a Part A or Part B appeal fails to send a copy of the request for hearing to other parties
A party submits written evidence later than 10 days after receiving the notice of hearing
The hearing is rescheduled at the request of the appellant
Missing material evidence identified by the ALJ at the hearing
The appellant waived right to appear at the hearing and subsequently withdrew waiver
The appellant waived the adjudication period for a specific period time agreed to by the ALJ and the appellant
A party requests discovery from another party to the ALJ hearing
A party requests a copy of all or part of the record and an opportunity to comment on the record
A Federal court stays the proceedings
Stay by Appellant request
Defective appointment of Representative
Request for information from Level 2

Select “Yes” to set a Tolling/Delay Event alert

Delay Event Start Date * 10/20/2022 (mm/dd/yyyy)

Reason for Delay Event * The appellant in a Part A or Part B appeal fails to send a cc

Delay Event Alert ● Yes ○ No

Notes

Expected End Date * (mm/dd/yyyy)

Expected Days In Delay Event *

Actual End Date (mm/dd/yyyy)

Actual Days in Delay Event

Save

Enter the Expected End Date and Select "Save." This will generate a notice in your Alert Queue the day after the Expected End Date.

Delay Event Start Date * 10/20/2022 (mm/dd/yyyy)

Reason for Delay Event * The appellant in a Part A or Part B appeal fails to send a cc

Delay Event Alert Yes No

Notes

Expected End Date * (mm/dd/yyyy)

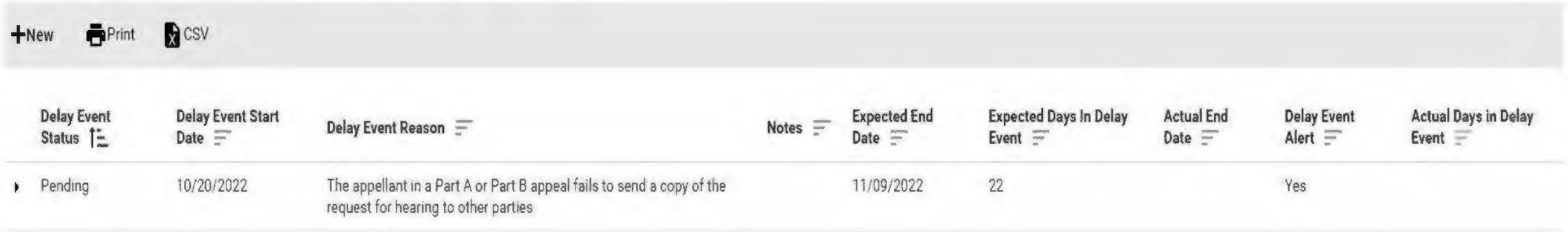
Expected Days In Delay Event *

Actual End Date (mm/dd/yyyy)

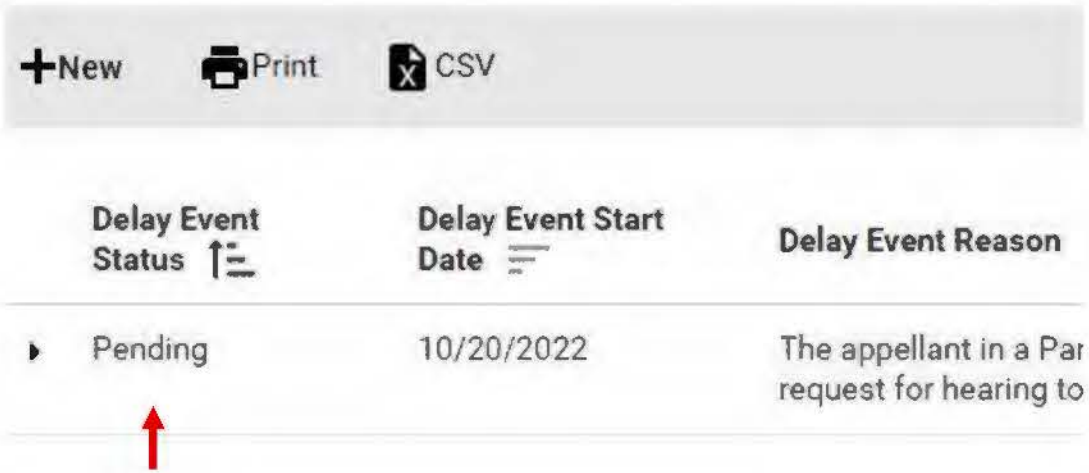
Actual Days in Delay Event

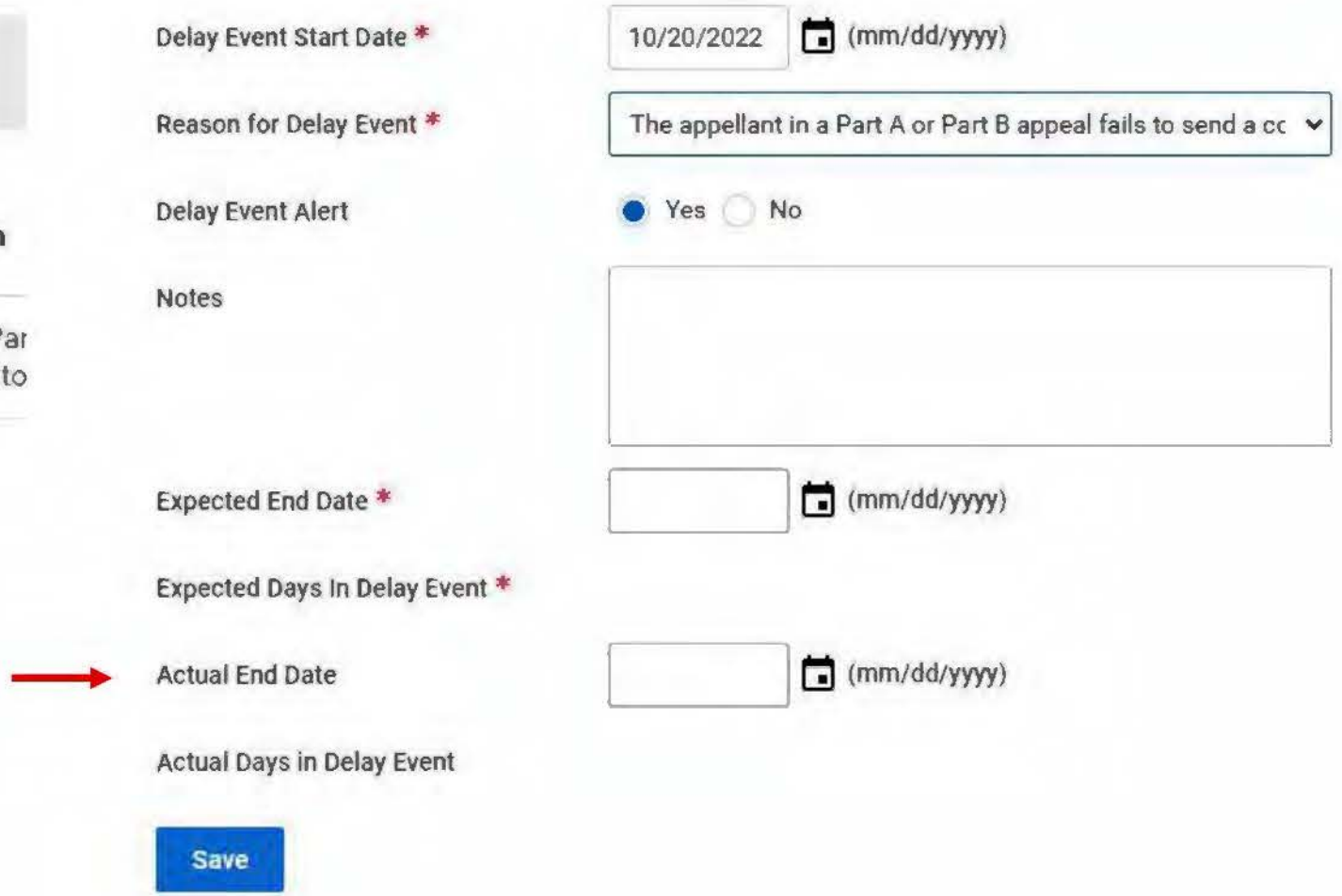
Save

The Tolling/Delay event is now created. The event will now appear under the Tolling/Delay Event Listing tab.



Once the event actually ends, the user will open the Event Listing (left image), enter a value in the Actual End Date field (right image), and select “Save.”





ECAPE
Adjudication
Time Frame Waiver

ECAPE Adjudication Time Frame Waiver

- New functionality expected second half of CY 2023.
- Interim Solution
  - Create a Tolling/Delay Event
  - Under "Reason for Tolling/Delay Event" select

"The Appellant waived the adjudication period for a specific period time agreed to by the ALJ and the appellant"

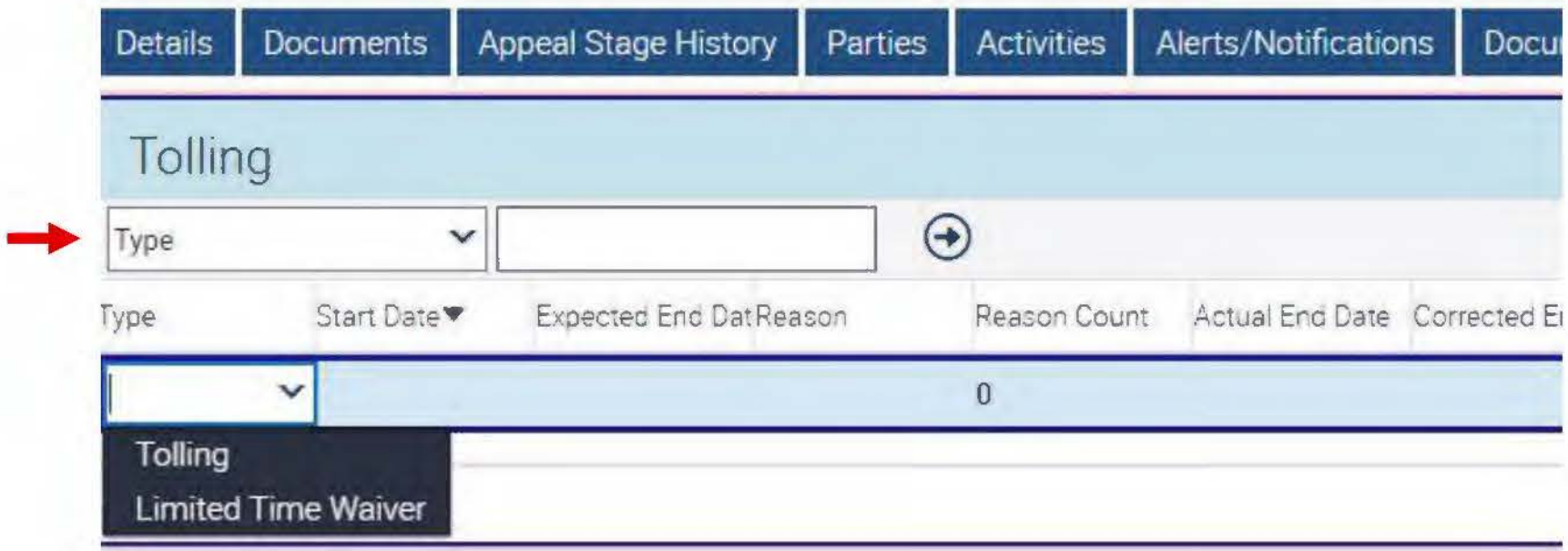
  - Set "Expected End Date" with an approximate date the appeal will close.
  - As needed, periodically update the "Expected End Date" to a future date
  - On the date the appeal is closed, input the closing date as the "Actual End Date" to complete the tolling event. **(***)**

MAS Tolling/Delay Event Entries

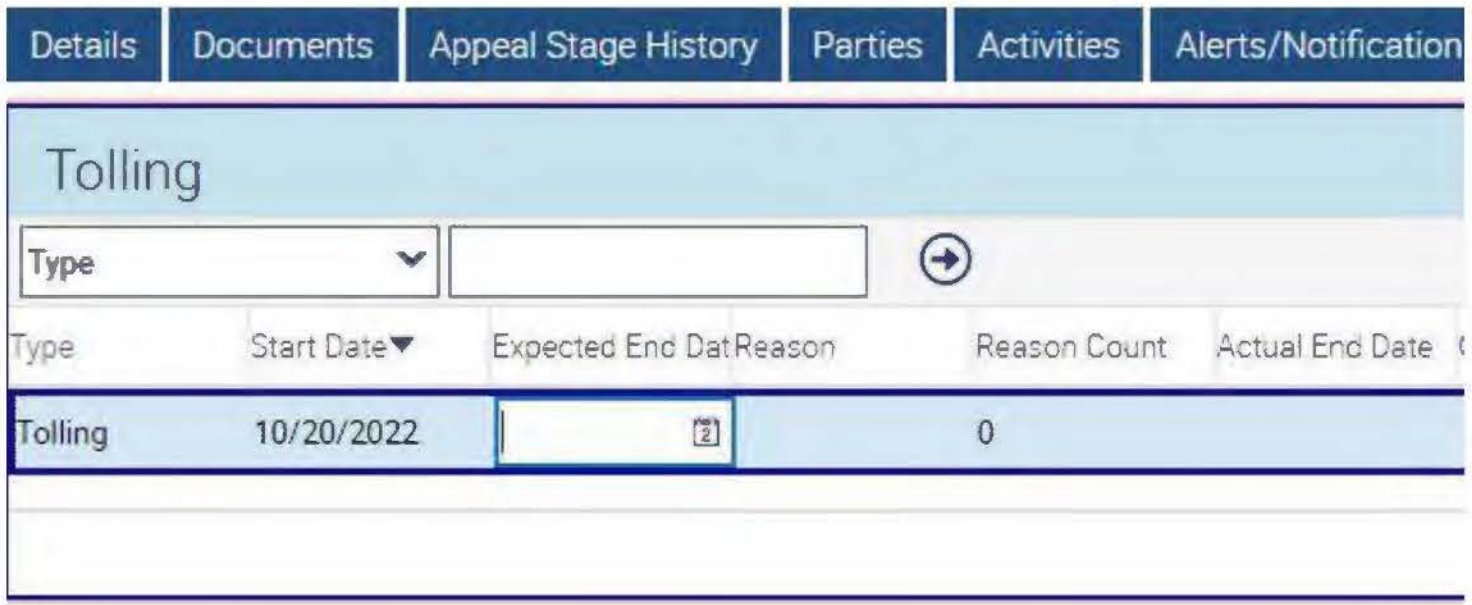
- To perform a tolling event in MAS:
  - Pull up the appeal record by searching for the corresponding ALJ number
  - Select the blue Tolling tab (if not visible, expand your tab option using the drop down option on the far right of the blue tab row)
  - Select the "+" icon to create new tolling event

- From the “Type: dropdown menu, select “Tolling”

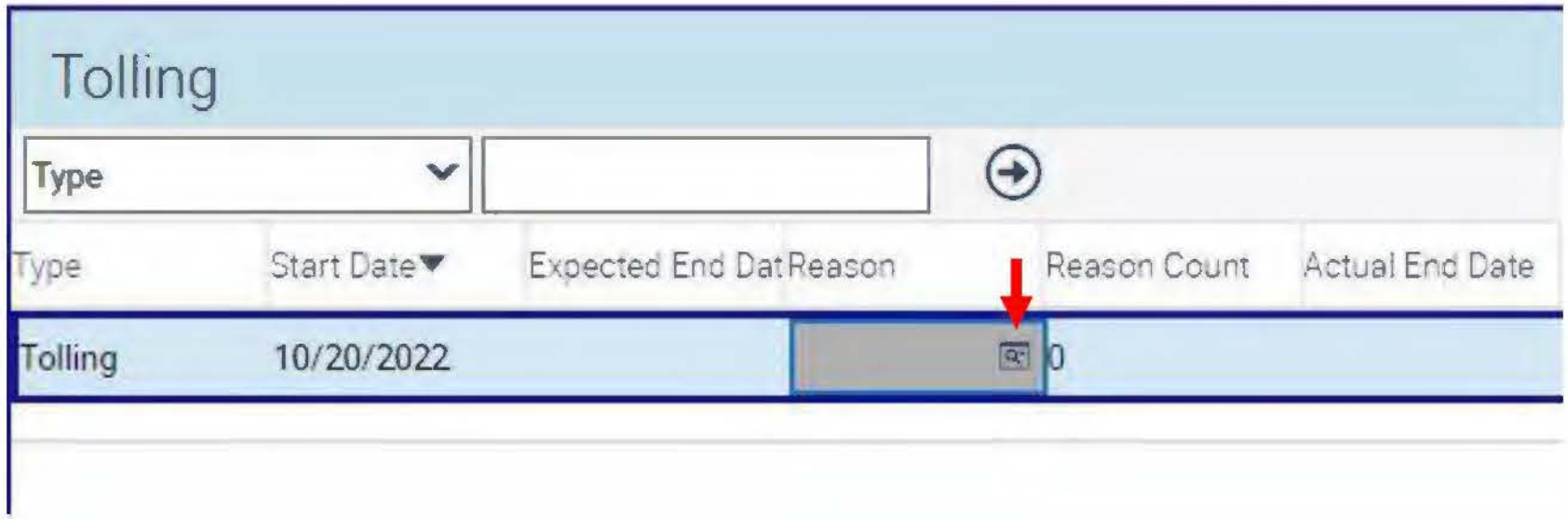
  (Note: when you make this selection, the “Start Date” will automatically populate with the current date.)



- Enter a date in the “Expected End Date” column



- Under the “Reason” column, select the icon.



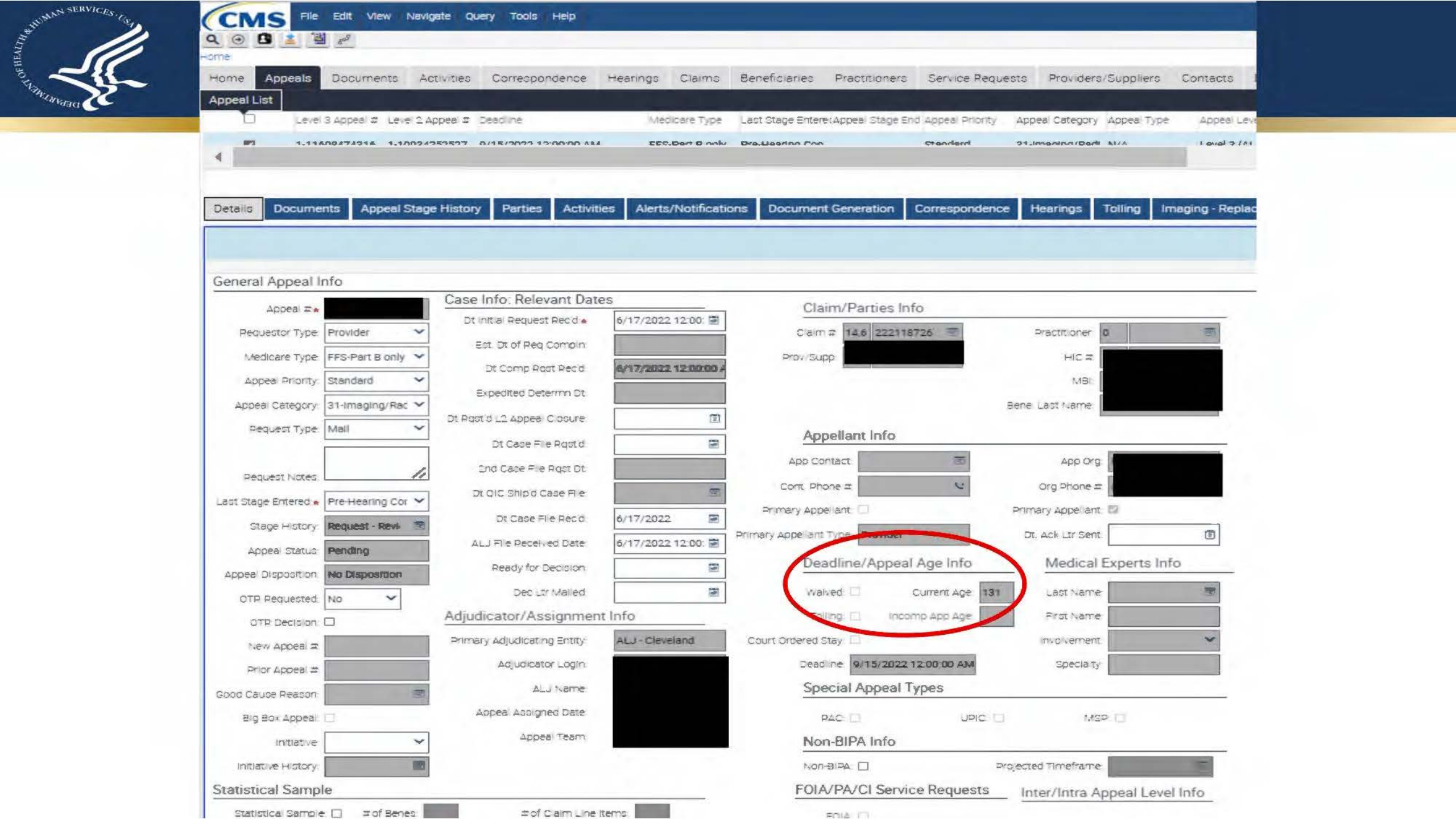
- A Reason box will appear. Click on the “+” icon to see the reasons for the tolling event

Select the option that best describes the reason for the tolling event

The completed tolling box should now be populated with the Reason, Type, and Start Date

- When the tolling event is completed, the user will enter the actual completion date in the “Actual End Date” column

MAS Adjudication Time Frame Waiver


CMS
File Edit View Navigate Query Tools Help
Home
Home Appeals Documents Activities Correspondence Hearings Claims Beneficiaries Practitioners Service Requests Providers/Suppliers Contacts
Appeal List
Level 3 Appeal # Level 2 Appeal # Deadline Medicare Type Last Stage Entered Appeal Stage End Appeal Priority Appeal Category Appeal Type Appeal Level
Details Documents Appeal Stage History Parties Activities Alerts/Notifications Document Generation Correspondence Hearings Tolling Imaging - Replac
General Appeal Info
Appeal #
Requestor Type: Provider
Medicare Type: FFS-Part B only
Appeal Priority: Standard
Appeal Category: 31-Imaging/Rac
Request Type: Mail
Request Notes:
Last Stage Entered: Pre-Hearing Cor
Stage History: Request - Revi
Appeal Status: Pending
Appeal Disposition: No Disposition
OTP Requested: No
OTP Decision:
New Appeal #:
Prior Appeal #:
Good Cause Reason:
Big Box Appeal:
Initiative:
Initiative History:
Case Info: Relevant Dates
Dt Initial Request Recd: 6/17/2022 12:00:
Est. Dt of Req Complin:
Dt Comp Rqst Recd: 6/17/2022 12:00:00 A
Expedited Determn Dt:
Dt Rqst'd L2 Appeal Closure:
Dt Case File Rqst'd:
2nd Case File Rqst Dt:
Dt QIC Ship'd Case File:
Dt Case File Recd: 6/17/2022
ALJ File Received Date: 6/17/2022 12:00:
Ready for Decision:
Dec Ltr Mailed:
Adjudicator/Assignment Info
Primary Adjudicating Entity: ALJ - Cleveland
Adjudicator Login:
ALJ Name:
Appeal Assigned Date:
Appeal Team:
Claim/Parties Info
Claim #: 14 6 222118726
Prov/Supp:
Practitioner: 0
HIC #:
MBI:
Bene Last Name:
Appellant Info
App Contact:
Cont. Phone #:
Primary Appellant:
Primary Appellant Type:
App Org:
Org Phone #:
Primary Appellant:
Dt. Ack Ltr Sent:
Deadline/Appeal Age Info
Waived:
Tolling:
Court Ordered Stay:
Current Age: 131
Incomp App Age:
Deadline: 9/15/2022 12:00:00 AM
Medical Experts Info
Last Name:
First Name:
Involvement:
Specialty:
Special Appeal Types
PAC: UPIC: MSP:
Non-BIPA Info
Non-BIPA:
Projected Timeframe:
Statistical Sample
Statistical Sample: # of Benes: # of Claim Line Items:
FOIA/PA/CI Service Requests
Inter/Intra Appeal Level Info

Deadline/Appeal Age Info

Waived: ☐

Tolling: ☐

Court Ordered Stay: ☐

Current Age: 131

Incomp App Age:

Deadline: 9/15/2022 12:00:00 AM

Scheduling

Scheduling

Unless the parties waive* the advance notice period and agree to the notice being mailed, transmitted, or served, as set forth below:

Standard Appeals

At least 20 days before the **standard appeals** hearing

Expedited Appeals

Notice of a hearing may be provided **orally** only for an expedited Part D appeal but must be followed by written notice within 1 calendar day of the oral notice.

At least 3 days for **expedited** Part D hearing or within 1 calendar day of providing oral notice of an expedited Part D hearing.

* The waiver must be in writing. ***See*** **OCPM 14.5.6.**

Deadline and 20-day Scheduling Waivers

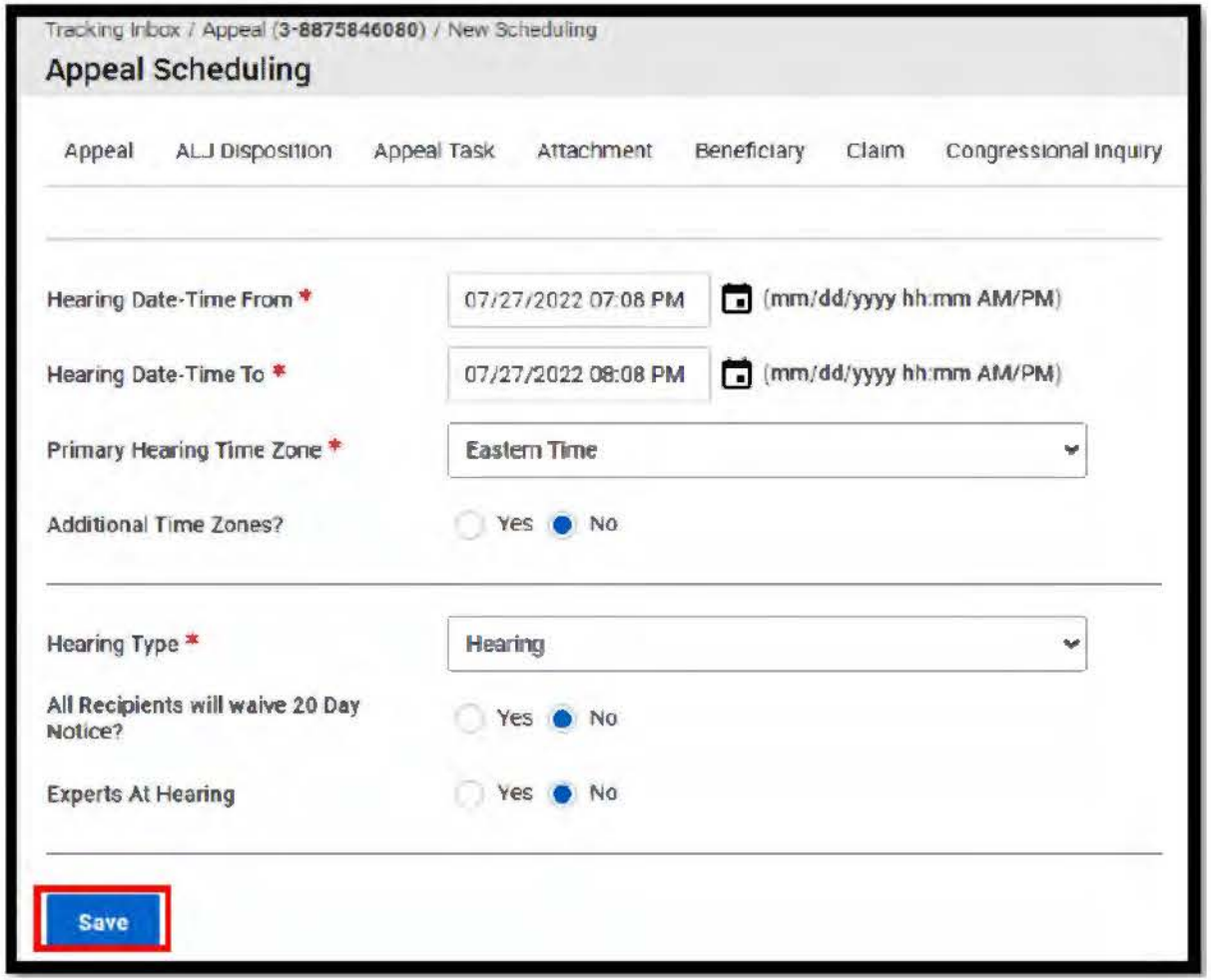
What are they?

20-day waivers: submitted as a written, voluntary act of giving up a right to schedule the ALJ Hearing within the 20-day timeframe. Appellant agrees that the ALJ hearing can be scheduled before 20 days. (In such cases – Expedited Pt D appeals).

When to pursue/strategize

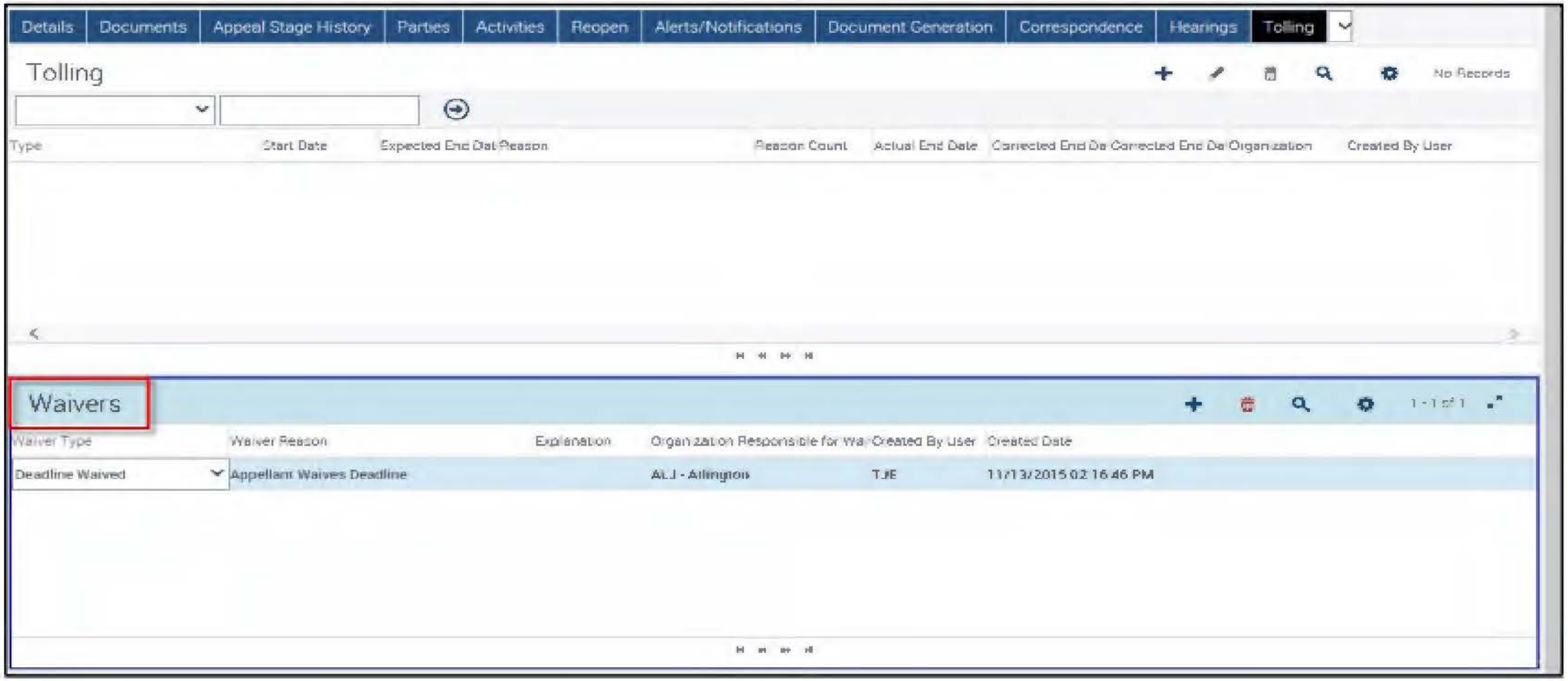
If an appellant requests or agrees to a hearing date fewer than 20 calendar days (or 3 calendar days expedited Part D) before the hearing, you may refer them to complete the OMHA-143 form (Waiver of Advance Written Notice of Hearing). The form waives the advance written notice requirement and provides consent to receive notice fewer than 20 calendar days (or 3 calendar days) before the hearing date.

How to put into ECAPE



How to put into MAS

Waivers Screenshot.



Best practice: How far out can you schedule?

It is a best practice to schedule an appeal as soon as possible to accommodate the 90-day adjudication timeframe.

The Benchmarking Guide can provide a framework; however, the ALJ sets the time and place for a hearing. 42 C.F.R. § 405.1020(a).

Best Practices: Blind Scheduling

Contacting the appellant or other parties before scheduling the hearing is not required, *unless* the notice of the hearing will not be mailed, transmitted, or served on time. **OCPM 14.3.1 and OCPM 14.5.6.**

If the appellant or representative has requested a specific date and time for the hearing and it does not conflict with the ALJ's current hearing calendar, you may schedule that hearing per their request. However, the date and time *must* still meet the time frame requirements for ALL individuals involved in the appeal.

Best Practice: Exceptions to Blind Scheduling – Calling First

Beneficiary Appeals: contact beneficiary prior to setting a hearing date.

OMHA prioritizes beneficiary-initiated cases to mitigate the impact that workload may have on adjudication times for individual Medicare beneficiaries. Cases within a priority level are processed on a first-in/first-out basis.

(Ref. OCPM 14.3.1 and OCPM 7.4.2)

Best Practice: Exceptions to Blind Scheduling – Calling First

Big box Appeals: contact all parties prior to setting a hearing date.

- Big box appeals require additional tasks and therefore require more time for preparation/coordination:
- The number of parties, participants, and witnesses other than the appellant that will attend the hearing

(Complexities include: Multiple beneficiaries, multiple claims, multiple parties, expert witnesses, pre and post hearing maybe required).

Review Responses to Notice of Hearing

Waiver of 90 days checked

90-day Deadline waivers: submitted by the appellant as a written, voluntary act of giving up the right to the 90-day timeframe to adjudicate their appeal; (no adjudication time frame applies to issuing a decision, dismissal, or remand).

OCPM 7.3.1

Who may waive an adjudication time frame?

Only an appellant may waive an adjudication time frame.

Review Responses to Notice of Hearing

New time requested

If an appellant objects to the *time* or *place* of the hearing and the hearing is rescheduled for any of the reasons described in **OCPM 14.6.7.3**, any applicable adjudication time frame is *extended* by the time between the original hearing date and the rescheduled hearing date. **See OCPM 7.2.2**.

Review Responses to Notice of Hearing (continued)

• An objection to the *time* or *place* of the hearing must be made in writing *unless* the party is requesting that the hearing be rescheduled the day prior to the hearing or the hearing is an **expedited Part D** hearing

(*see* OCPM 14.6.7.2);

• An **objection to the issues** must be made in writing *unless* the hearing is an **expedited Part D** hearing

(*see* OCPM 14.6.8.2; § 42 CFR 405.1024 and 423.2024).

Objections can be selected on the OMHA-102 Response to Notice of Hearing, section 6.

A response may also be submitted by fax or email which qualifies as a response in writing.

What if two or more events that delay the start of or extend the adjudication time frame occur during the same time period?

If two or more events that delay the start of or extend the adjudication time frame *overlap*, the adjustment to the adjudication time frame begins on the date the *earlier* event starts and ends on the date that *all* events have concluded.

For events that *toll or extend* the adjudication time frame (see OCPM 7.3.2).

The End

90 DAY ADJUDICATION TRAINING: Part 1

FY 2023 OMHA BENCHMARKS (target dates)

- **By December 31, 2022:**
  - Move all appeals not in active tolling/delay with a Complete Request Received Date on or before **November 30, 2022**, to "Scheduled" state or "Hearing" stage (with a scheduled hearing date).
  - Close all appeals not in active tolling/delay with a Complete Request Received Date on or before **July 31, 2022.**
- **By January 31, 2023:**
  - Move all appeals not in active tolling/delay with a Complete Request Received Date on or before **December 31, 2022**, to "Scheduled" state or "Hearing" stage (with a scheduled hearing date).
  - Close all appeals not in active tolling/delay with a Complete Request Received Date on or before **September 30, 2022**.
- **By March 1, 2023:**
  - Move all appeals not in active tolling/delay with a Complete Request Received Date on or before **January 31, 2023**, to "Scheduled" state or "Hearing" stage (with a scheduled hearing date).
  - Close all appeals not in active tolling/delay with a Complete Request Received Date on or before **November 30, 2022.**
  - All OMHA adjudicators must be processing all Medicare Part A and Part B appeals within the 90-day statutory time frame. Also, OMHA's prioritization of beneficiary appeals will continue, pursuant to our regulations and internal goals, requiring 90-day adjudication for all Part D, QIO, Part C and SSA appeals, as well as 10-day adjudication for all expedited Part D appeals.

Benchmarking Guide[1]

ECAPE Benchmarks

Day Range	Number of Calendar Days	Number of Calendar Days Remaining	Beginning ECAPE State	Recommended ALJ Action	Team or Pool Member Action[2]	Ending ECAPE State
Day 1 – Day 12	12	78	**In Central Operations**	N/A	N/A	**ALJ Assigned**
Day 13 – Day 17	5	73	**ALJ Assigned**	Create and assign **Pre-Schedule Review** Task to Team Legal Assistant or to Pool "Supervisor"	Complete **Pre-Schedule Review** Task; Enter Tolling or Delay event, if applicable[3]	**Ready to Schedule**
Day 18 – Day 27	10	63	**Ready to Schedule**	Create and assign **Exhibiting** and **Scheduling** Tasks to Team Legal Assistant or to Pool "Supervisor"	Complete **Scheduling** Task	**Scheduled**
Day 28 – Day 55	28	35	**Scheduled**	Complete **Scheduled** State by saving initiated hearing	Complete **Exhibiting** Task; Enter Tolling or Delay event, if applicable[4]	**Hearing**
Day 56 Day 60	5	30	**Hearing**	Advance to **Decision Writing** State (draft decision writing instructions) and create and assign **Decision Writing** Task to Team Attorney or to Pool "Supervisor" or Advance to **Post Hearing Development** State	Upload hearing audio; Enter Tolling or Delay event, if applicable[5]	**Decision Writing**
Day 61 – Day 80	20	10	**Decision Writing**	Monitor Decision Writing progress	Complete **Decision Writing** Task; Advance to **Review and Sign** State	**Review and Sign**
Day 81 – Day 85	5	5	**Review and Sign**	Complete **Review and Sign** State;	N/A	**Review and Close**
Day 86 Day 90	5	0	**Review and Close**	Create and assign **Appeal Closing** Task to Team Legal Assistant or to Pool "Supervisor"	Complete **Appeal Closing** Task	**Pending Closed**

[1] These benchmarks were developed by Headquarters and Field Office Senior Leadership by analyzing ECAPE and MAS data. The Benchmarking Guide is designed to assist you in achieving 90-day adjudication. As we transition into a 90-day adjudication environment, we will continue to review and revise these benchmarks as more data becomes available.
[2] Update status from "Pending" to "In Progress" when beginning any Task.
[3] The start of the 90-calendar day adjudication time frame, where applicable, may be delayed or the time frame may be extended in certain circumstances identified in OCPM 7.2.
[4] *Id.*
[5] *Id.*

MAS Benchmarks

Day Range	Number of Calendar Days	Number of Calendar Days Remaining	Beginning MAS Stage	Recommended ALJ Action	Team or Pool Member Action	Ending MAS Stage
Day 1 – Day 12	12	78	**In Central Operations**	N/A	N/A	**Assignment**
Day 13 Day 17	5	73	**Assignment**	Assign **Procedural** review to Team Legal Assistant or to Pool "Supervisor"	Open **Procedural** Stage; Perform **Procedural** review; Close **Procedural** Stage; Enter Tolling or Delay event, if applicable[6]	**Procedural**
Day 18 – Day 27	10	63	**Procedural**	Assign **Exhibiting** and **Scheduling** to Team Legal Assistant or to Pool "Supervisor"	Open **Exhibiting** Activity; Perform **Exhibiting**; Open **ALJ Hearing** Stage; **Schedule** appeal	**Hearing**
Day 28 – Day 55	28	35	**Hearing**	Hold Hearing	Close **Exhibiting** Enter Tolling or Delay Event, if applicable[7] Close **ALJ Hearing** Stage;	**Hearing**
Day 56 – Day 60	5	30	**Hearing**	Draft Decision Writing Instructions and assign to Team Attorney or to Pool "Supervisor" Or Assign **Post Hearing**	Open **Decision** Stage Or Open/Close **Post Hearing** Stage and enter Tolling or Delay Event, if applicable[8]	**Decision**
Day 61 – Day 80	20	10	**Decision**	Monitor Decision Writing progress	Write **Decision**; Close **Decision** Stage	**Decision**
Day 81 – Day 85	5	5	**Decision**	Review and Sign Decision Assign Appeal Closing to Team Legal Assistant or to Pool "Supervisor"	N/A	**Decision**
Day 86 – Day 90	5	0	**Decision**	Monitor workflow progress	Close appeal; Move to **Closed** Stage	**Closed**

[6] The start of the 90-calendar day adjudication time frame, where applicable, may be delayed or the time frame may be extended in certain circumstances identified in OCPM 7.2.
[7] *Id.*
[8] *Id.*

The 90 Day Deadline

90 Day Deadline - History

- **The Medicare, Medicaid, and SCHIP *Benefits Improvement and Protection Act* of 2000 (BIPA)**
  - All Part A/B appeals that received a QIC reconsideration

- **2009 Part D Final Rule**
  - Standard Part D appeals

  See 74 Fed. Reg. 65339 (Dec. 9, 2009)

- **OMHA Case Prioritization Policy (Internal)**

  CJB 13-002 (retired), CJB 15-002 (retired), OCPM Ch. 7, §7.4 (current)

- **OMHA FY 2023 Performance Goals (Internal)**
  - All Appeals

Council Remands and the Adjudicatory Deadline

- If the Council remands a case, the remanded appeal will be subject to the adjudication time frame beginning on the date that OMHA receives the Council remand.

  See 42 C.F.R. §§ 405.1016(b)(2), 423.2016(b)(2).

Statutory/Regulatory 90 Day Deadline

- Part A/B appeals that received a QIC reconsideration
- Standard Part D appeals

OMHA Policy Based 90 Day Internal Goal

- Part C Appeals
- Entitlement and IRMAA appeals that received a SSA reconsideration
- Appeals that received a QIO reconsideration

Calculating the 90 Day Deadline

When Does the 90 Day Adjudication Period Begin?

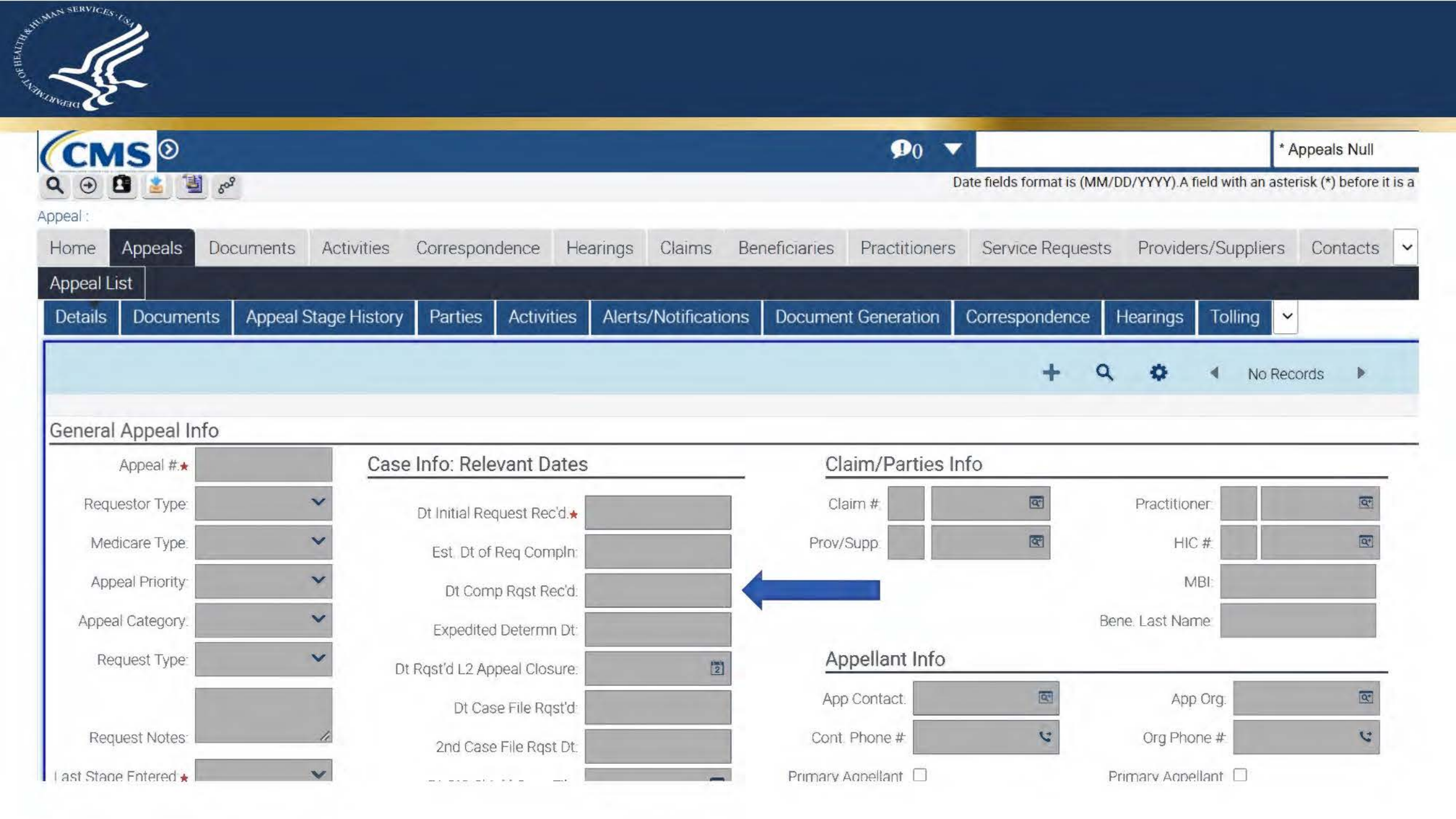
- When a RFH that satisfies all regulatory content and copy requirements is filed with the office specified in the reconsideration decision or dismissal
- When OMHA receives a Council Remand
- Note: Central Ops is the designated office for receiving all RFHs and Remands.

The Complete Request Received Date

- Denotes the date on which the 90 Day Adjudication period begins
- ECAPE field
- MAS version is "Date Complete Request Received"

Appeal | ALJ Disposition | Appeal Task | Attachment | Beneficiary | Cla

ECAPE ID	E11366
OMHA Appeal No.	3-100639
Reconsideration #	1-100639
Request Received Date *	05/27/2020
Complete Request Received Date *	05/27/2020 (mm/dd/yyyy)
Incorrect Entity Received Date	(mm/dd/yyyy)
Statutory Deadline Date	08/24/2020
Decision Letter Mailed Date	
Current Age	878
Has Active Tolling Event(s)?	No
Medicare Type	Part A
Appeal Category	Other Surgery


CMS
0
* Appeals Null
Date fields format is (MM/DD/YYYY).A field with an asterisk (*) before it is a
Appeal :
Home
Appeals
Documents
Activities
Correspondence
Hearings
Claims
Beneficiaries
Practitioners
Service Requests
Providers/Suppliers
Contacts
Appeal List
Details
Documents
Appeal Stage History
Parties
Activities
Alerts/Notifications
Document Generation
Correspondence
Hearings
Tolling
No Records
General Appeal Info
Appeal #:
Requestor Type:
Medicare Type:
Appeal Priority:
Appeal Category:
Request Type:
Request Notes:
Last Stage Entered
Case Info: Relevant Dates
Dt Initial Request Rec'd.
Est. Dt of Req Compln:
Dt Comp Rqst Rec'd:
Expedited Determn Dt:
Dt Rqst'd L2 Appeal Closure:
Dt Case File Rqst'd:
2nd Case File Rqst Dt:
Claim/Parties Info
Claim #:
Prov/Supp:
Practitioner:
HIC #:
MBI:
Bene. Last Name:
Appellant Info
App Contact:
Cont. Phone #:
Primary Appellant
App Org:
Org Phone #:
Primary Appellant

Events that Affect the Start of the 90 Day Adjudication Period

- The Appellant's RFH does not satisfy the regulatory content requirements

  42 C.F.R. § 405.1014(b)(1).

- The Appellant files the RFH with an office other than that specified in the reconsideration decision or dismissal

  42 C.F.R. § 405.1014(c)(2).

- The Appellant (other than unrepresented Beneficiary/Enrollee) fails to send a RFH copy to the other parties who were sent the QIC decision.

  42 C.F.R. § 405.1014(d)(1).

NOTE: These are not TOLLING/DELAY events.

Events that Affect the Start of the 90 Day Adjudication Period (cont.)

- If a RFH is untimely filed and the adjudicator grants an extension to the filing deadline.

  42 C.F.R. § *405.1014(e)(4)*

How Do These Events Relate to the Complete Request Received Date

- Complete Request Received Date changes
- That change triggers recalculation of the 90 Day Deadline

NOTE: These are not TOLLING/DELAY events.

Regulatory RFH Content Requirements

- Name address, and Medicare health number of the beneficiary whose claim is being appealed, and the beneficiary's telephone number if the beneficiary is the appealing party and not represented.
- Name, address, and telephone number, of the appellant, when the appellant is not the beneficiary.
- Name, address, and telephone number, of the designated representative, if any.
- Medicare appeal number or document control number, if any, assigned to the QIC reconsideration or dismissal notice being appealed.
- Dates of service of the claim(s) being appealed, if applicable.
- Reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed.

See 42 C.F.R. § 405.1014(a)(1)

What Date To Input Into the Complete Request Received Date

- **If the RFH does not satisfy the regulatory content requirements** → input the receipt date of the completed RFH (normally in response to a cure letter).

- **If the adjudicator finds good cause to extend the filing deadline for an untimely RFH** → input the date the adjudicator grants the filing deadline extension.

- **If the Appellant (other than unreprestend Bene/Enrollee) fails to send a RFH copy to the other parties** → input the receipt date of evidence that the RFH was properly copied (normally in response to a cure letter).

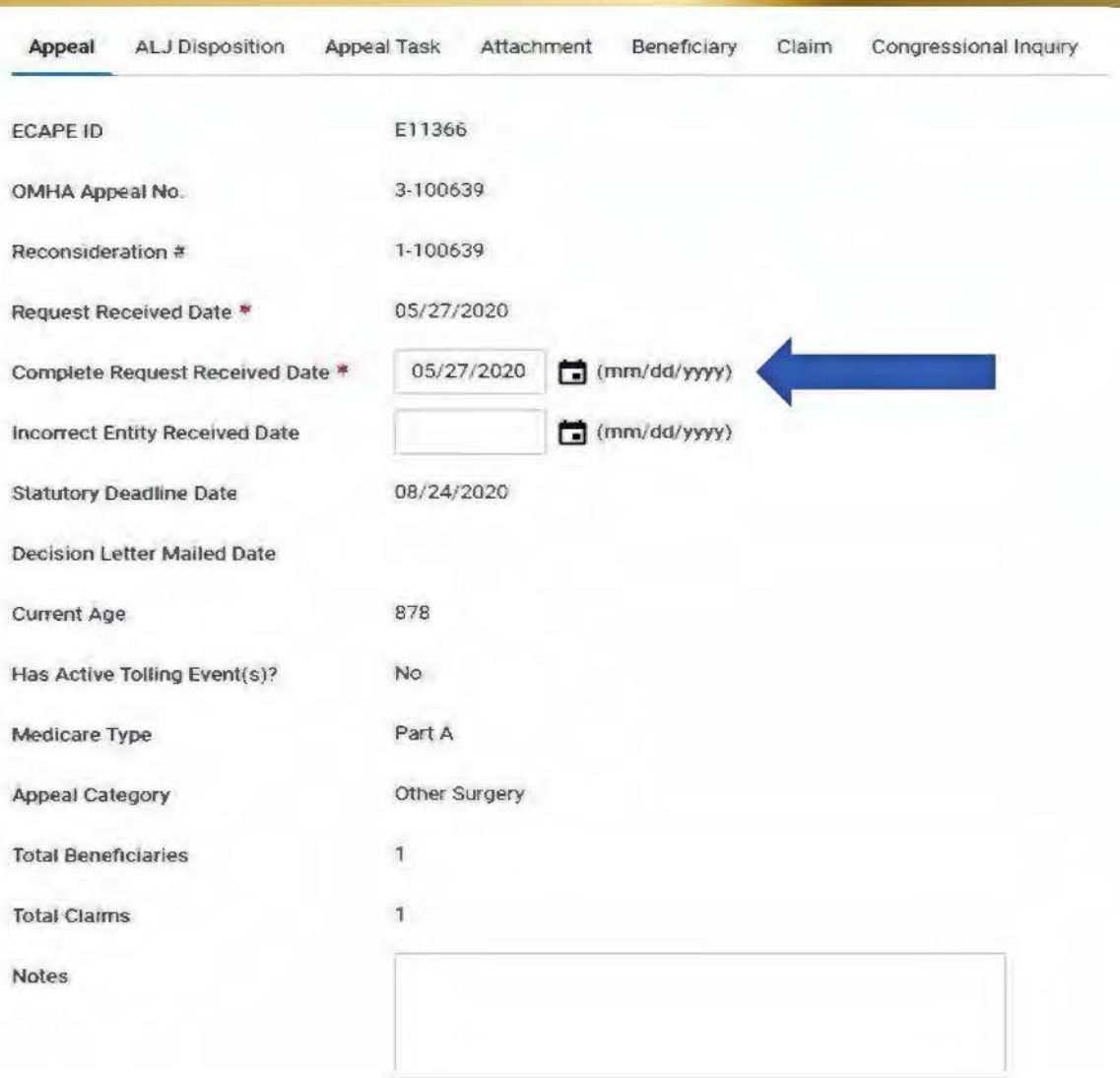
- **If the RFH is filed with an office other than that specified in the reconsideration decision or dismissal** → input the date the specified office (i.e. Central Ops) receives the RFH. (Note: this change is typically performed by Central Ops when docketing the request for hearing).

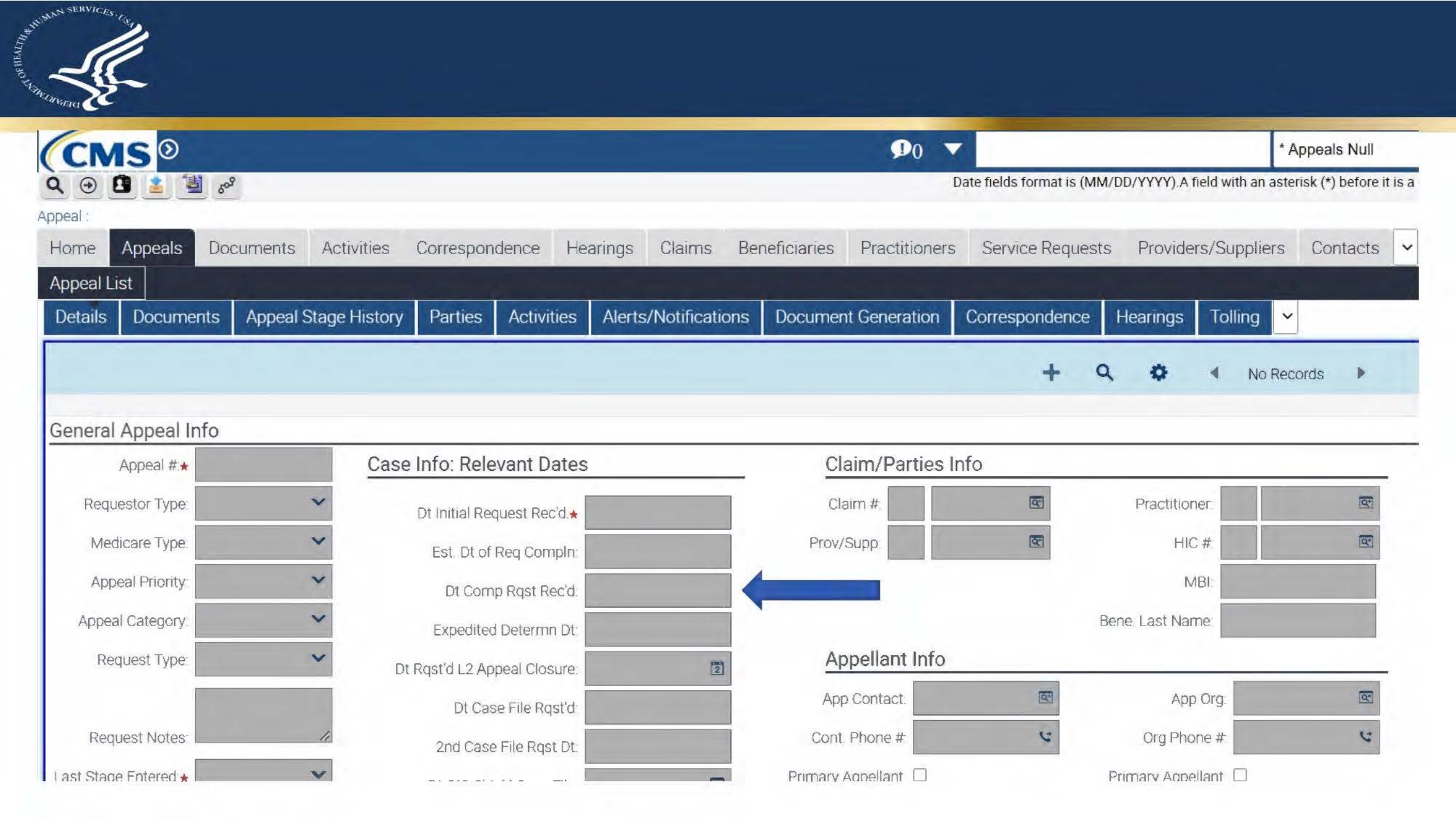
Updating the Complete Request Received Date

- ECAPE Appeals: ALJ Team members currently have access to manually edit this field when appropriate.

- MAS Appeals: ALJ Team members must email the necessary information to the user in your office who has a MAS System Administrator role.

Manually Update the Complete Request Received Date in ECAPE and select “Save”




CMS
0
* Appeals Null
Date fields format is (MM/DD/YYYY).A field with an asterisk (*) before it is a
Appeal :
Home
Appeals
Documents
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Correspondence
Hearings
Claims
Beneficiaries
Practitioners
Service Requests
Providers/Suppliers
Contacts
Appeal List
Details
Documents
Appeal Stage History
Parties
Activities
Alerts/Notifications
Document Generation
Correspondence
Hearings
Tolling
No Records
General Appeal Info
Appeal #:
Requestor Type:
Medicare Type:
Appeal Priority:
Appeal Category:
Request Type:
Request Notes:
Last Stage Entered
Case Info: Relevant Dates
Dt Initial Request Rec'd.
Est. Dt of Req Compln:
Dt Comp Rqst Rec'd:
Expedited Determn Dt:
Dt Rqst'd L2 Appeal Closure:
Dt Case File Rqst'd:
2nd Case File Rqst Dt:
Claim/Parties Info
Claim #:
Prov/Supp:
Practitioner:
HIC #:
MBI:
Bene. Last Name:
Appellant Info
App Contact:
Cont. Phone #:
Primary Appellant
App Org:
Org Phone #:
Primary Appellant

Tolling/Delay Event Overview

What Is a Tolling/Delay Event?

- It presumes that the adjudication time frame has already started (vs. events that affect the 90 Day start date.)
- It extends the applicable adjudication time frame based on a qualifying event that occurs during the life of the appeal.
- It effectively pauses the 90 day clock on the date the event begins and restarts it on the date the event ends.

Difference Between Tolling and Delay Events

Tolling Event → Appeals with Statutory/Regulatory 90 Day Deadlines

- Part A/B appeals that received a QIC reconsideration
- Standard Part D appeals

Delay Event → Appeals with OMHA Policy Based 90 Day Internal Goal

- Part C Appeals
- Entitlement and IRMAA appeals that received a SSA reconsideration
- Appeals that received a QIO reconsideration

➢Qualifying Tolling/Delay Events:

- Defective appointment of Representative
- Request for information from Level 2
- A party submits written evidence later than 10 days after receiving the notice of hearing
- The appellant waived right to appear at the hearing and subsequently withdrew waiver
- The hearing is rescheduled at the request of the appellant
- The ALJ continues the hearing at the request of the Appellant
- The appellant waived the adjudication period for a specific time agreed to by the ALJ and appellant
- A party requests discovery from another party to the ALJ hearing
- A party requests a copy of all or part of the record and an opportunity to comment on the record
- A federal court stays the proceedings
- Stay by appellant request

See OCPM Ch. 7, § 7.2.2.

Tolling/Delay Event Timeframes

Defective Appointment of Representative

- Tolling/Delay event begins from whichever of the following events is later:

  1) the date that a defective AOR was filed, or
  2) the date the appeal request was filed by the prospective appointed representative.

- Tolling/Delay event ends the date the defect was cured, or the party provided notification that they will proceed without representation

Request for Missing information (RFI) from CMS contractor, a Plan or SSA

- Tolling/Delay event begins the date of the RFI
- Tolling/Delay event ends whichever of the following events is earlier:
  1) The date the entity responds; or
  2) 20 calendar days after the date of the RFI

Tolling/Delay Event Timeframes (cont.)

- **A party submits written evidence later than 10 days after receiving the Notice of Hearing**
  - Determine the Notice of Hearing receipt date (NOH mail date + 5 days)
  - Tolling/Delay event begins 10 days after hearing receipt date
  - Tolling/Delay event ends on the date of receipt of the new evidence

- **The appellant waived right to appear at the hearing and subsequently withdraws waiver**
  - Tolling/Delay event begins on the date the appellant withdrew the waiver
  - Tolling/Delay event ends on the date of the hearing

- **The hearing is rescheduled at the request of the appellant**
  - Tolling/Delay event begins on the original hearing date
  - Tolling/Delay event ends on the date the hearing is conducted

Tolling/Delay Event Timeframes (cont.):

- **The ALJ continues the hearing at the request of the Appellant**
  - Tolling/Delay event begins on the date of the initial hearing
  - Tolling/Delay event ends on the date of the continued hearing
- **The appellant waived the adjudication period for a specific time agreed to by the ALJ and appellant**
  - Tolling/Delay event begins and ends pursuant to the terms of the agreement and will be relative to the circumstances
  - See OCPM Ch 7, § 7.3.4 for examples
- **A Federal court stays the proceedings (other than a general bankruptcy court order)**
  - Tolling/Delay event begins on the date of the stay order
  - Tolling/Delay event ends pursuant to the terms of the Court Order

Tolling/Delay Event Timeframes (cont.)

- **A party requests discovery from another party to the ALJ hearing**
  - Tolling/Delay event begins on the date the discovery request is granted
  - Tolling/Delay event ends on the date specified by the ALJ for ending discovery

- **A party requests a copy of all or part of the record and an opportunity to comment on the record**
  - Tolling/Delay event begins on the date of receipt of the request
  - Tolling/Delay event ends on ALJ set deadline for the party's comments

Tolling/Delay Event Timeframes (cont.)

- **ALJ grants appellant's motion to stay proceedings**
  - Tolling/Delay event begins and ends pursuant to the terms of the stay order, provided no other party also filed a RFH on the same claim at issue.

- **Adjudicator withdraws from an appeal pursuant to a party's objection to the adjudicator's assignment to the case**
  - The applicable adjudication time frame is extended by 14 calendar days.

Adjudication Time Frame Waivers

What is an Adjudication Time Frame Waiver (Deadline Waiver)?

- A written statement, from the Appellant, indicating that he or she is waiving the adjudication time frame.
- Only an Appellant may initiate an adjudication timeframe waiver.

  See OCPM Ch. 7, § 7.3

How Long Is the Deadline Waived?

- A waiver is typically complete, in which case no adjudication time frame applies.

- An Appellant may submit a limited time waiver that extends the adjudicatory deadline for a specified period of time, similar to a tolling/delay event.

Making the Waiver

- Appellant's waiver must be in writing and be exhibited to the administrative record.
- The writing must clearly reflect that the Appellant is waiving the adjudication timeframe.
- Appellant may use Section 7 on the Response to Notice of Hearing form (OMHA-102).
- Appellant may otherwise submit a written waiver at any time during the life of the OMHA appeal.

☐ **I object to the ALJ assigned to my appeal.** I understand that an ALJ cannot adjudicate an appeal if he or she is prejudiced or partial with respect to any party or has an interest in the matter pending for decision, and that I may object to the ALJ assigned to my appeal for these reasons. I understand that the ALJ will consider my objection and decide whether to proceed with the appeal or withdraw. I understand that if I object to the ALJ assigned to my appeal, and the ALJ subsequently withdraws from the appeal, another ALJ will be assigned, and any applicable adjudication time frame will be extended by 14 calendar days.

I object to the assigned ALJ because:

Section 7: If you are the appellant, do you want to waive or extend the time frame to decide your appeal? (*If yes, check one*)

☐ **I want to waive the time frame for the ALJ to decide my appeal.** I understand that by waiving this time frame, the ALJ does not have to decide my appeal within any applicable adjudication period that would otherwise apply.

☐ **I want to extend the time frame for the ALJ to decide my appeal.** I want the time frame to be extended _____ calendar days beyond any applicable adjudication period.

Section 8: Sign and date this form.

Party, Participant or Representative Signature	Date
[redacted]	10/13/22

Privacy Act Statement

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.

If you need large print or assistance, please call 1-855-556-8475

Waiver Solicitation

- An adjudicator or adjudication team member may not solicit a deadline waiver, including the following situations:
  - The adjudicator's workload volume prevents timely adjudication.
  - The size or complexity of the case prevent timely adjudication.
  - A hearing is scheduled/rescheduled to accommodate the ALJ's schedule.

- Limited Circumstance: The adjudicator may suggest a waiver when the appellant makes a procedural request that will delay the case or otherwise prevent the adjudicator from meeting the adjudicatory deadline.

  See examples at OCPM Ch. 7, § 7.3.4.

System Access and Power BI

MAS Workload

- Paper case remands from the Council
- IRMAA (Cleveland workload only)

MAS Access Issues

- Please contact your ACALJ/HOD or whomever, in your field office, is responsible for coordinating MAS accounts for guidance

POWER BI

- Web based software service that provides data organization and reports.
- OMHA uses Power BI to provide staff access to various Workload Dashboards.
- The Dashboards are refreshed every morning at 10am Eastern.
- Excellent Pending Workload management tool for Legal Assistants, Legal Administrative Specialists, Attorney Advisors, SALJs and others.

To discuss access to OMHA's Power BI Dashboards, contact your field office ACALJ/HOD for further assistance.

Power BI Dashboard link:

https://app.powerbigov.us/groups/me/apps/3aabf4d3-c077-45c5-b404-4df05b0afb80/reports/828426f9-9ef3-4be2-9512-6149018c0e2c/ReportSection5dccf10eba1331490893

10/20/2022

Oldest Data Refresh

Oz-Training

Field Office

APPEALS IN WORKFLOW STATE BY ALJ

Office	ALJ Assigned	Ready to Schedule	Scheduled	Hearing	Post Hearing Development	Decision Writing	Review & Sign	Review and Close	Total
⊟ Oz-Training	17	111	264	4	8	189	19	4	616
Dorthy	10	17	17			50	3	2	99
Glinda		9	129		1	23			162
Lion	6	73	69	4		8	14	2	176
The Wizard						20			20
Toto	1	12	49		7	84	2		155
Tin Man						4			4
Total	**17**	**111**	**264**	**4**	**8**	**189**	**19**	**4**	**616**

Complete RFH Date

11/9/2021 10/13/2022

Office

All

Team

All

Aged Level

- Select all
- < Deadline
- 1-30 Days Past De...
- 31-90 Days Past D...
- 91-120 Days Past ...
- >120 Past Deadline

Appeal Priority

- Select all
- 2-Priority
- 4-Standard

Active Tolling/Del...

- Select all
- No
- Yes

In Stage Days

- Select all
- 0-10
- 11-20
- 21-30
- 31-40
- 41-50

Aged Case

- No

Big Box

- No
- Yes

Oz-Training

Field Office

10/21/2022

Oldest Data Refresh

NUMBER OF DAYS APPEAL IN WORKFLOW STATE NOT IN ACTIVE TOLLING/DELAY

Team	Ready to Schedule	Scheduled	Post Hearing Development	Decision Writing	Review & Sign	Total
⊟ Tin Man	12	49	7	84	2	154
>50	8	29	7	27		71
41-50	1	2		15		18
31-40	1			12		13
21-30	1	3		1	2	7
11-20	1	5		9		15
0-10		10		20		30
Total	12	49	7	84	2	154

Office
All

Team
Tin Man

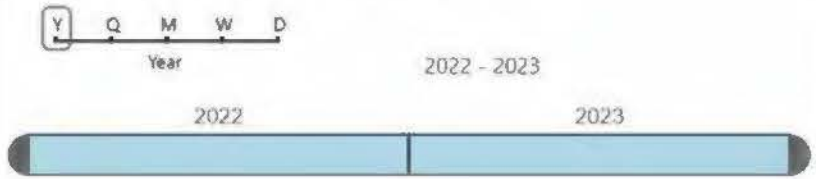
Aged_Level
- Select all
- < Deadline
- 1-30 Days Past De...
- 31-90 Days Past D...
- 91-120 Days Past ...
- >120 Past Deadline

Appeal Priority
- Select all
- 2-Priority
- 4-Standard

BIPA
- BIPA
- Non-BIPA

Aged Case
- No

Complete Req. Rec. Date (FY Qtr)



United States Department of Health & Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS

Oz-Training

Field Office

APPEALS IN WORKFLOW STATE BY ALJ

Team	ALJ Assigned	Ready to Schedule	Scheduled	Hearing	Post Hearing Development	Decision Writing	Review & Sign	Review and Close	**Total**
Tin Man		300	47		3	8			**358**
Dorthy					5	101	2	19	**344**
Glinda	2					90	61	1	**339**
Lion	1			1	1	91	4		**296**
The Wizard	3				2	33	3	36	**199**
Toto						17		1	**18**
Total	**6**					**340**	**70**	**57**	**1554**

Team	Appeal #	Appellant	Provider	Representative	Requestor Name	Requestor Type	Workflow State	Days In Stage	Appeal Priority	Medicare Type	Category	Processing Method
Tin Man	3-7392589970R1	GEM AMBULANCE LLC	GEM AMBULANCE LLC			Provider	Ready to Schedule	461	4-Standard	Part B	Ground Transportation	
Tin Man	3-7592836808	NORTHUMBERLAND EMERGENCY GROUP, PC	NORTHUMBERLAND EMERGENCY GROUP, PC	SUBSIDIUM HEALTHCARE LLC			Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7596801746	POPLAR BLUFF EMERGENCY PHYSICIANS, LLC	POPLAR BLUFF EMERGENCY PHYSICIANS, LLC	SUBSIDIUM HEALTHCARE LLC			Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600728591	INDEPENDENT EMERGENCY PHYSICIANS, P.C.	INDEPENDENT EMERGENCY PHYSICIANS, P.C.	EMERGENCY GROUPS' OFFICE		Non-Attorney	Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600729244	INDEPENDENT EMERGENCY PHYSICIANS, P.C.	INDEPENDENT EMERGENCY PHYSICIANS, P.C.			Provider	Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600729356	INDEPENDENT EMERGENCY PHYSICIANS, P.C.	INDEPENDENT EMERGENCY PHYSICIANS, P.C.	EMERGENCY GROUPS' OFFICE		Non-Attorney	Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600818796	MONTEREY BAY OBSERVATION MEDICINE	MONTEREY BAY OBSERVATION MEDICINE	EMERGENCY GROUPS' OFFICE		Non-Attorney	Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600818910	MERCED HOSPITALIST MEDICAL GROUP, INC.	MERCED HOSPITALIST MEDICAL GROUP, INC.	EMERGENCY GROUPS' OFFICE		Non-Attorney	Ready to Schedule	461	4-Standard	Part B	Outpatient Hospital / ASC	
Tin Man	3-7600818984	MERCED HOSPITALIST MEDICAL GROUP, INC.	MERCED HOSPITALIST MEDICAL GROUP, INC.	EMERGENCY GROUPS' OFFICE		Non-Attorney	Ready to Schedule	461	4-Standard	Part B	Hospital E/M Services	

Module 10: Ambulance Transportation Services

Lesson Objectives

At the completion of this lesson, you will be able to:

1. Define the ambulance benefit;
2. Understand Medicare's coverage and payment rules for ambulance services;

Lesson Objectives (cont'd)

3. Explain the different levels of ambulance services;
4. Apply the limitation on liability rules to ambulance cases.

Objective 1

THE AMBULANCE BENEFIT

The Benefit

2 components of the benefit:

- Social Security Act § 1861(s)(7)
- 42 C.F.R. §§ 410.40 - 410.41

Social Security Act § 1861(s)(7)

Medicare pays for ambulance service where the use of other methods of transportation is **contraindicated** by the individual's condition, but only to the extent provided in **regulations.**

Regulations

42 C.F.R. § 410.40

- Medical necessity requirements
- Origin and destination requirements
- Levels of service (42 C.F.R. § 414.605 incorporated by reference)
- Documentation requirements (e.g., physician certification statement)

Regulations (cont'd)

42 C.F.R. § 410.41

- Vehicle, staff, billing, and reporting requirements

Objective 1 Test

- What are the two components of the ambulance benefit?
- Which regulation covers the vehicle, staff, billing, and reporting requirements?
- Which regulation covers the medical necessity, origin and destination, and documentation requirements?

Objective 2

COVERAGE & PAYMENT RULES

Coverage and Payment Rules Overview

Medicare covers ambulance transportation services under Part B, if the following four conditions are met:

- The supplier meets the applicable vehicle, staff, and billing and reporting requirements;
- The service is medically necessary;

Coverage and Payment Rules Overview
(cont'd)

- The service meets the origin and destination requirements; and
- Medicare Part A payment is not made directly or indirectly for the services.

Vehicle, Staff, Billing and Reporting Requirements

Vehicle Requirements: Any vehicle used as an ambulance must:

- Be designed to respond to medical emergencies;
- Be equipped with emergency lights and sirens;

Vehicle, Staff, Billing and Reporting Requirements (cont'd)

- Be equipped with telecommunication equipment; and
- Be equipped with a stretcher, linens, medical supplies, oxygen equipment, and other lifesaving medical equipment.

Vehicle, Staff, Billing and Reporting Requirements (cont'd)

Staffing Requirements:

- At least two crew members, certified in accordance with State and local laws.
- *BLS vehicles*: At least one crew member must be certified as an Emergency Medical Technician-Basic (EMT-Basic).

Vehicle, Staff, Billing and Reporting Requirements (cont'd)

- *ALS vehicles*: At least one crew member must be certified as an Emergency Medical Technician-Intermediate (EMT-Intermediate) or Paramedic.

Vehicle, Staff, Billing, and Reporting Requirements (cont'd)

Billing and Reporting Requirements:

- Suppliers must bill using the proper HCPCS codes.
- Suppliers must bill using the proper origin and destination codes.
- Suppliers must keep documentation showing compliance with the vehicle, staff licensure, and certification requirements.

Medically Necessary

Medical necessity is established when the patient's condition is such that use of **any** other method of transportation is "contraindicated."

- E.g., private vehicle, taxi, wheelchair van, or stretcher van.
- Regardless of whether such other transportation is actually available.

Contraindication

CMS ***presumes*** other means of transportation are contraindicated if the beneficiary:

- Was transported in an emergency situation (e.g., as a result of an accident, injury or acute illness);
- Needed to be restrained to prevent injury to themselves or others;

Contraindication (cont'd)

- Was unconscious or in shock;
- Required oxygen or other emergency treatment during transport;
- Exhibited signs and symptoms of acute respiratory distress or cardiac distress (e.g., shortness of breath or chest pain);

Contraindication (cont'd)

- Exhibited signs and symptoms of acute stroke;
- Had to remain immobile because of the possibility of a fracture;
- Was experiencing severe hemorrhage;
- Could be moved only by stretcher; or
- Was bed-confined before and after the ambulance trip.

Nonemergency Ambulance Transportation

Nonemergency transportation is medically necessary if:

The beneficiary is **bed-confined**, **and** it is documented that the beneficiary's condition is such that other methods of transportation are **contraindicated; OR**

- The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required; **AND**
- The provider obtains a **physician certification statement**.

Bed Confinement

A beneficiary is bed-confined if:

- The beneficiary is unable to get up from bed without assistance; and
- The beneficiary is unable to ambulate; and
- The beneficiary is unable to sit in a chair or wheelchair.

Physician Certification Statement

A Physician Certification Statement (PCS) is a signed physician's order for the nonemergency ambulance transport. The rules vary depending on the type of transport:

- Unscheduled or Non-Repetitive Transport: The supplier must obtain a PCS from the beneficiary's attending physician within **48 hours after** the transport.

Physician Certification Statement (cont'd)

- Scheduled, Repetitive Transport: The PCS must be dated no earlier than **60 days before** the date of the transport.

Physician's Medical Necessity Certification

Complete for non-emergency scheduled and non-emergency unscheduled ambulance transport(s). This applies to Repetitive Transports and/or One-Time Transport(s).

1

PATIENT'S NAME	HEALTH INSURANCE CLAIM NUMBER (Medicare number)
[redacted]	

TRANSPORT DATE	TRANSPORTED FROM	TRANSPORTED TO
1/5/2012	[redacted]	[redacted]

AMBULANCE SERVICE PROVIDED BY: Respect Ambulance

In order for ambulance services to be covered, they MUST be medically necessary and reasonable. Medical necessity is established when **the patient's condition is such that transportation by other means is contraindicated.** Please complete the questions below in order for the ambulance claim to be evaluated under Medicare coverage criteria.

2

The Health Care Financing Administration has defined "bed confinement" as (all three bullets must be met):

The patient is:

- unable to get up from bed without assistance; ***and***
- unable to ambulate; ***and***
- unable to sit in a chair or wheelchair.

1) Is the patient bed-confined as defined by the above definition? ☑ Yes ☐ No

2) If **No**, please check the **appropriate medical conditions listed below**

3

This patient:

- ☑ requires restraints to prevent harm and/or injury to self or others (provide explanation in other)
- ☐ requires cardiac monitoring
- ☐ requires continuous oxygen monitoring by trained staff **NOTE: patients who are generally mobile with portable oxygen would not require non-emergency ambulance transportation based solely on the need for oxygen.**
- ☐ had to remain immobile because of a fracture that had not been set or the possiblity of a fracture (i.e., hip fracture)
- ☐ is ventilator dependent
- ☐ requires continuous IV therapy
- ☐ other, please specify, Morbid obesity;

I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical record of the patient. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers such as the Medicare program. I understand that any intentional misrepresentations or falsification of essential information, which leads to inappropriate payments, may be subject to investigations under applicable federal and/or state laws.

4

NAME	TITLE	TELEPHONE NUMBER
[redacted]	Office Coordinator	[redacted]
ADDRESS [redacted]		
SIGNATURE [redacted]	DATE 1/6/12	

If the ambulance supplier is unable to obtain a signed physician certification statement from the attending physician, a signed physician certification must be obtained from either **the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner** who is employed by the hospital or facility where the beneficiary is being treated and who has personal knowledge of the beneficiary's condition at the time of transport.

Physician Certification is good 60 days from the date of the physician's signature

Origin and Destination Requirements

Medicare covers ambulance transportation from any point of origin to the **nearest appropriate facility** capable of furnishing the required level and type of care for the beneficiary's illness or injury.

Appropriate Facilities

The term "appropriate facilities" means that the institution is generally equipped to provide the needed care for the beneficiary's illness or injury.

- The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the beneficiary is irrelevant.

Appropriate Facilities (cont'd)

- Exception: The beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital.

Covered Destinations

Medicare covers ambulance transportation only to the following destinations:

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);

Covered Destinations (cont'd)

- Beneficiary's home;
- Nearest supplier of medically necessary services not available at SNF where beneficiary is resident;
- Dialysis facility for ESRD patient who requires dialysis.

Part A Payment for Ambulance Services

A service that is covered and payable as a beneficiary transportation service under Part A cannot be classified and paid as an ambulance service under Part B.

Part A Payment for Ambulance Services
(cont'd)

Ambulance transportation furnished by a hospital to an **inpatient** is a service covered under Part A.

- If either the origin or the destination of the ambulance transport is the beneficiary's home, then the ambulance transport is paid separately by Part B.
- If both the origin and destination of the ambulance transport are providers, like a hospital, CAH, or SNF, then payment may be made under Part A as a packaged hospital service.

Part A Payment for Ambulance Services

Example 1:

Transportation by ambulance to and from another hospital to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient **and the patient is still admitted as an inpatient** is paid under Part A.

Part A Payment for Ambulance Services
(cont'd)

Example 2:

Transportation by ambulance to and from another hospital to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient **and the patient is discharged** is paid under Part B.

Air Ambulance Cases

Air ambulance transport services are covered if:

- The vehicle and crew requirements described in 42 C.F.R. § 410.41 are met;
- The beneficiary's medical condition required **immediate and rapid ambulance transportation** that could not have been provided by ground transportation; and either

Air Ambulance Cases (cont'd)

- The pickup point is inaccessible by ground vehicle; OR
- Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities.

Immediate and Rapid Transport

Immediate and Rapid Transport: The beneficiary's condition is such that the time needed to transport the beneficiary by ground poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health.

When Ground Ambulance is Inappropriate

As a general guideline, when it would take a ground ambulance **30-60 minutes** or more to transport a beneficiary whose medical condition at the time of pickup required immediate and rapid transport, then air transportation is appropriate.

Immediate and Rapid Transport

Examples of covered conditions:

- Intracranial bleeding requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a burn center;

Immediate and Rapid Transport (cont'd)

- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries;
- Life-threatening trauma.

Objective 2 Test

- What are the three elements of bed confinement?
- Is nonemergency ambulance transport covered if a beneficiary is just bed confined?
- Is ambulance transportation covered from the beneficiary's home to a dialysis center?

Objective 2 Test (cont'd)

- A beneficiary is transported by air ambulance from a local hospital to the Mayo Clinic instead of the regional hospital because Mayo Clinic has the best doctors. Is the mileage to the Mayo Clinic covered?

Objective 3

DIFFERENT LEVELS OF AMBULANCE SERVICES

7 Levels of Ambulance Services

Types of Ground Ambulance Transport

- Basic Life Support (emergency and non-emergency)
- Advanced Life Support 1 (emergency and non-emergency)
- Advanced Life Support 2 (**emergency only**)
- Paramedic ALS Intercept
- Specialty Care Transport

Types of Air Ambulance Transport

- Fixed Wing Transport
- Rotary Wing Transport

Emergency vs. Non-Emergency

- An emergency response is an immediate response to a 911 call at the BLS or ALS1 level of service.
- An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.
- A non-emergency response is all other types of responses.

HCPCS Codes for Ambulance Services

A0425	BLS mileage (per mile)
A0425	ALS mileage (per mile)
A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
A0427	Ambulance service, ALS, emergency transport, Level 1
A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport
A0429	Ambulance service, basic life support (BLS), emergency transport
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers.
A0433	Ambulance service, advanced life support, level 2 (ALS2)
A0434	Ambulance service, specialty care transport (SCT)
A0435	Air mileage; FW, (per statute mile)
A0436	Air mileage; RW, (per statute mile)

Origin and Destination Codes

- D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
- E = Residential, domiciliary, custodial facility (other than 1819 facility);
- G = Hospital based ESRD facility;
- H = Hospital;

Origin and Destination Codes (cont'd)

I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;

J = Freestanding ESRD facility;

N = Skilled nursing facility;

P = Physician's office;

Origin and Destination Codes (cont'd)

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

Example: If a supplier bills for ALS1 transportation (A0426) for transportation from an individual's home to a hospital, the service would be coded as A0426-RH

Basic Life Support (BLS)

BLS is the most basic and common form of ground ambulance transportation

Requirements:

- Vehicle must be **staffed by at least 2 people** who meet the certification requirements of state and local laws; and
- At least 1 of the staff members must be certified as an **EMT-Basic**

Advanced Life Support 1 (ALS1)

ALS1 is a more intense form of ground ambulance transportation

Requirements:

- An **ALS assessment** (only performed in **emergency** responses); OR
- At least **one ALS intervention** (can only be performed by an EMT-Intermediate or EMT-Paramedic)

Advanced Life Support 2 (ALS2)

ALS2 is an even more intense ground ambulance transport and requires:

- At least 3 separate administrations of intravenous or continuous infusion medications; OR
- At least 1 of the ALS2 procedures

ALS2 Procedures

- Manual defibrillation
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Paramedic ALS Intercept (PI)

- PI are ALS services furnished by an entity that does not furnish the ground ambulance transport.
- **Example**: A local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient, but the patient needs ALS services. A separate entity will dispatch an EMT-Paramedic to the scene to provide the ALS services.

Specialty Care Transport (SCT)

SCT is an **interfacility transportation** of a critically injured beneficiary by ground ambulance.

Specialty Care Transport (SCT) (cont'd)

SCT is appropriate if a beneficiary requires a level of service beyond the scope of the EMT-Paramedic such as:

- Emergency or critical care nursing
- Emergency medicine
- Respiratory care
- Cardiovascular care.

Air Ambulance Transport

There are 2 categories of air ambulance services:

- **Fixed Wing Transport** (airplane)
- **Rotary Wing Transport** (helicopter)

Air Ambulance Transport (cont'd)

The higher operational costs of these two types of ambulance transport are recognized with two **distinct payment amounts for mileage**:

- **A0435** Fixed Wing mileage
- **A0436** Rotary Wing mileage

Objective 3 Test

- What are the seven levels of ambulance services?
- What are the 2 categories of air ambulance transport, and what is special about both levels of service?

Objective 3 Test (cont'd)

- Can a provider bill for non-emergency Advanced Life Support Level 2 (ALS2)?
- If a ground ambulance is staffed with 2 EMT-Basic personnel, and responds to a non-emergency call, can the provider bill for Advanced Life Support Level 1 (ALS1)?

Objective 4

LIMITATION ON LIABILITY RULES

Financial Liability-General

In general, section 1879 liability protection only applies when coverage is denied because the services were not medically "reasonable and necessary" under section 1862(a)(1)(A) of the Act.

Financial Liability-Ambulance

Unlike most services, the statutory basis for denying ambulance services is section 1861(s)(7) NOT section 1862(a)(1).

Section 1861(s)(7) of the Act, incorporates by reference the following regulations:

- 42 C.F.R. § 410.40
- 42 C.F.R. § 410.41
- 42 C.F.R. § 414.605

Financial Liability - Exception

Limitation on liability (Act § 1879) *could* apply when payment is fully or partially denied as unreasonable, for example:

- Air transport was provided when ground transport would have sufficed;
- A level of care downgrade, e.g., from Advanced Life Support to Basic Life Support;

Financial Liability – Exception (cont'd)

- Transport to a hospital when the service could have been provided more economically at home.

Objective 4 Test

- Do the limitation on liability provisions apply when a claim is denied because the services were not medically reasonable and necessary?
- Do the limitation on liability provisions apply when ambulance services are denied for failure to comply with the origin and destination requirements?

Objective 4 Test (cont'd)

- Do the limitation on liability provisions apply when ambulance services are denied because the beneficiary was not bed-confined?
- Do the limitation on liability provisions apply when air ambulance services are denied because ground ambulance services were more appropriate?

Summary

Now you should be able to:

1. Define the ambulance benefit;
2. Understand Medicare's coverage and payment rules for ambulance services;
3. Explain the different levels of ambulance services; and
4. Apply the limitation on liability rules to ambulance cases.

Module 11 - The Medicare Drug Benefit

Medicare Part B – Drugs and Biologicals

Medicare Part D – Voluntary Prescription Drug Benefit Program

Lesson Objectives (1-2)

After this session, you will be able to:

- Understand the scope of benefits covered as Medicare Part B Drugs and Biologicals;
- Detail the requirements for coverage of a Part B Drug or Biological;
- Identify examples of self-administered drugs that are covered/non-covered by Medicare Part B;

Lesson Objectives (2-2)

- Understand the general scope of benefits covered under the Medicare Part D Program;
- Gain familiarity with Part D law and policy;
- Recognize common issues that arise in Part D appeals; and,
- Know how to process expedited Part D appeals.

Part B Drugs & Biologicals (1-2)

Part B only covers drugs and biologicals furnished incident to physician services that are not usually self-administered.

- Caveat: Certain self-administered drugs and biologicals are covered, such as blood-clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs.

CMS, *Medicare Benefit Policy Manual* (*MBPM*), (*Internet Only Manual Publ'n 100-02*) ch. 15, § 50.

Part B Drugs & Biologicals (2-2)

Generally, drugs and biologicals are covered under Medicare Part B only if all of the following requirements are met:

- They meet the definition of drugs or biologicals;
- They are not usually self-administered;
- They meet the requirements for coverage as incident to a physician's services;
- They are reasonable and necessary;
- They are not excluded as non-covered immunizations; and
- They have not been determined by the FDA to be less than effective.

Labeled Use

Labeled use = FDA-approved use

- FDA approved drugs/biologicals are deemed safe and effective when used for indications specified on the labeling.
- Contractors will deny drugs/biologicals which have not been approved by the FDA, unless they receive contrary instructions from CMS.

Off-label Use – NON Anti-Cancer Drug

Off-label use = a use that is not included as an indication on the drug's label as approved by the FDA.

An off-label use may be covered by Medicare if the use is determined to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature, and/or accepted standards of medical practice.

Off-label Use – Anti-Cancer Drug

Off-label use of an anti cancer drug = a use that is not included as an indication on the drug's FDA-approved label.

The following compendia have been approved by the Secretary for determining whether an unlabeled use of an anti-cancer drug is a medically accepted indication:

- American Hospital Formulary Service Drug Information (AHFS-DI);
- National Comprehensive Cancer Network Drugs and Biologicals Compendium (NCCN);
- Micromedex DRUGDEX;
- Clinical Pharmacology; and
- Lexi-Drugs (effective August 12, 2015).

Self Administered Drugs

Some examples of self-administered drugs covered under Part B:

- Blood Clotting Factors;
- Parenteral and enteral nutrition (intravenous and tube feeding);
- Immunosuppressive drug therapy;
- Erythropoietin (EPO) (for the treatment of anemia with chronic renal failure who are on dialysis);
- Certain Oral Anti-Nausea and Anti-Cancer Drugs

Medicare Part D

Part D (the Medicare Voluntary Prescription Drug Benefit Program) is an optional prescription drug benefit program for individuals:

- Who are entitled to Medicare benefits under Part A; or
- Who are enrolled in Medicare benefits under Part B.

Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual eligibles) automatically receive the Medicare Part D drug benefit.

What is a Part D Drug

In general, a Part D-covered drug (42 C.F.R. § 423.100) must meet all of these conditions:

- Available only by prescription;
- Approved by the Food and Drug Administration (FDA);
- Used and sold in the U.S.;
- Used for a medically accepted indication, as defined under the Social Security Act; and
- Not covered under Part A or Part B.

Act §§ 1860D-2(e)(1), 1927(k)(2)(A).

What is a "Medically Accepted Indication" under Part D (1-2)

"Medically accepted indication" refers to the diagnosis or condition for which a drug is prescribed.

For non anti-cancer drugs, a medically accepted indication is:

- Any FDA-approved use; or
- Any use supported by one or more citations included or approved for inclusion in the recognized compendia:
  - AHFS-DI
  - DRUGDEX

Act § 1927(g)(1)(B)(i).

What is a "Medically Accepted Indication" under Part D (2-2)

For anti-cancer drugs, a medically accepted indication is:

- Any FDA-approved use; or,
- Any use supported by one or more citations included or approved for inclusion in the recognized compendia:
  - AHFS-DI;
  - NCCN;
  - DRUGDEX;
  - Clinical Pharmacology; and,
  - Lexi-Drugs (effective August 12, 2015)

Act §§ 1860D-2(e)(4)(A)(i), 1861(t)(2)(B); *MBPM*, *supra* ch. 15, § 50.4.5.

Part D Exceptions Process (1-2)

Formulary Exception:

- Must be a Part D drug.
- Must be medically necessary.
- Would be covered *but for* non-formulary status.

Tiering Exception:

- Must be a higher tier drug.
- Must be medically necessary.
- Cannot be granted *in addition* to a formulary exception.

Part D Exceptions Process (2-2)

- Exception requires physician's statement (oral or written) that all formulary or lower tier alternatives:
  1) Would not be as effective as the requested drug; and/or,
  2) Would likely have adverse effects.
- Exception lasts until end of plan year.
- May request exceptions to step-therapy, prior authorization, dosage, etc.

42 C.F.R. § 423.578.

Part D Law and Policy (1-3)

Statute

- Social Security Act § 1860D-1
- Social Security Act § 1860D-2
- Social Security Act § 1927(g)
- Social Security Act § 1927(k)

Regulations

- 42 C.F.R. Part 423, Subparts M and U

Part D Law and Policy (2-3)

The Part D procedural sections are found in Subpart M and Subpart U.

- 42 C.F.R. Part 423, Subpart M "Grievances, Coverage Determinations, Redeterminations, and Reconsiderations" [42 C.F.R. §§ 423.558 to 423.638].
- 42 C.F.R. Part 423, Subpart U "Reopening, ALJ Hearings and ALJ and Attorney Adjudicator Decisions, Council Review, and Judicial Review" [in particular, 42 C.F.R. §§ 423.1968 to 423.2063].

Part D Law and Policy (3-3)

Policy

CMS, *MPDBM* (*Internet-Only Manual Publ'n 100-18*), includes:

- Appendix A: Common Acute Care Home Infusion Drugs.
- Appendix B: Part D Drugs/Supplemental Drugs Summary Table.
- Appendix C: Medicare Part B versus Part D Coverage Issues.
- Appendix D: The Most Commonly Prescribed Drug Classes for the Medicare Population.
- Appendix E: Sample Transition Supply Scenarios and Eligibility.

Common Issues In Part D Appeals (1-2)

Statutory exclusion – Prescription vitamins and minerals are excluded from coverage pursuant to § 1927(d)(2) of the Act. *See* M-14-2823 (Jan. 21, 2016).

Medically accepted indication - The drug was not prescribed or used for a medically accepted indication as listed on the FDA-approved label or cited in a Medicare-approved compendia. *See* M-15-1791 (Nov. 3, 2015).

Compound drug – Formulary exception not available because the component bulk pharmaceutical powders were not FDA-approved. *See* M-14-2483 (Mar. 12, 2015).

Non-formulary drug prescribed for off-label use – The prescribing physician did not submit a statement that all other alternatives on the formulary would be less effective and/or would have adverse effects. *See* M-15-1142 (Aug. 13, 2015).

Common Issues In Part D Appeals (2-2)

Formulary exception granted and enrollee requests tiering exception - Tiering exception never allowed *in addition* to formulary exception. *See* M-14-1876 (Oct. 16, 2014).

Enrollee requests tiering exception for non-preferred drug at generic level –PDP sponsor never required to cover a non-preferred drug at the generic rate. *See* M-14-3249 (Oct. 7, 2014).

Enrollee requests tiering exception for specialty drug – Specialty tier for high cost drugs not eligible for a tiering exception. *See* M-14-3559 (Apr. 1, 2015).

Citation to compendia – The ALJ relied on evidence outside of the record because the compendium entry was not admitted into evidence. *See* M-15-1616 (Jan. 6, 2016).

General Approach

- Identify the requested drug and prescribed use;
- Determine if there is a statutory exclusion;
- Check to see if the requested drug is on the particular formulary and the extent of its permitted use (indications, dosing, etc.);
- Determine if the requested drug is a Part D drug prescribed for a "medically accepted indication" (check approved compendia);
- If exception (formulary or tiering) is requested, assess whether the drug is:
    - Medically necessary;
    - Supported by the prescribing physician's statement that all formulary or lower tier alternatives (1) would not be as effective, and/or (2) would likely have adverse effects;
- If the ALJ decides the beneficiary's use of the drug is supported by one or more citations included or approved for inclusion in any compendia, a copy of the relevant compendia entries must be included in the record.

Module 12: Part B Durable Medical Equipment

Objectives (1 of 3)

At the completion of this module, you will be able to:

1. Identify the laws, regulations, and guidelines applicable to durable medical equipment (DME)
2. Explain who can order DME
3. Understand the definition of DME

Objectives (2 of 3)

4. Know the coverage requirements
5. Know the documentation requirements
6. Understand the difference between replacement and repair

Objectives (3 of 3)

7. Identify consolidated billing issues
8. Know the QIC's most common reasons and basis for denial

Applicable Regulations (1 of 7)

Section 1862(a)(1) of the Social Security Act allows Medicare to pay for "medical and other health services."

Section 1861(s)(6) of the Social Security Act defines the term "medical and other health services" to include durable medical equipment.

Applicable Regulations (2 of 7)

Section 1862(a)(6) of the Social Security Act states that no Medicare payment may be made for personal comfort items.

Applicable Regulations (3 of 7)

Under **Section 1861(n) of the Social Security Act,** the term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, wheelchairs, power-operated vehicle, blood-testing strips, blood glucose monitors, and seat-lift mechanism.

Applicable Regulations (4 of 7)

42 C.F.R. § 410.10(h) defines the term "medical and other health services" to include durable medical equipment.

Applicable Regulations (5 of 7)

42 C.F.R. § 410.38 describes the scope and conditions of durable medical equipment.

42 C.F.R. § 414.202 provides the definition for durable medical equipment.

Applicable Regulations (6 of 7)

42 C.F.R. § 424.57 (b)(2) states that suppliers (including physicians) that sell or rent Medicare covered DMEs are required to obtain a Medicare supplier number conveying billing privileges.

Applicable Regulations (7 of 7)

42 C.F.R. § 424.57 (c)(12) states that suppliers are responsible for delivery of DME items to a beneficiary and must also maintain proof of delivery.

National Coverage Determination (NCD)

Sample List

NCD 40.2 – Home Blood Glucose Monitors

NCD 240.2 – Home Use of Oxygen

NCD 280.1 – DME Reference List

NCD 280.3 – Mobility Assistive Equipment

NCD 280.7 – Hospital Beds

National Coverage Determination (NCD)

ALJs and attorney adjudicators are bound by NCDs pursuant to 42 C.F.R. § 405.1060(a)(4).

Medicare National Coverage Determinations Manual (Internet-Only Manual Publ'n 100-03)

NCD 280.1 – DME Reference List (1-2)

NCD 280.1 contains the DME Reference List. It is a quick reference tool for determining the coverage status of certain DME. This is not an exhaustive list of all DME. The list is organized into two columns. For Example:

NCD 280.1 – DME Reference List (2-2)

Item	Coverage
• Air Conditioner	• Deny- environmental control equipment; not primarily medical in nature.
• Spare Tank of Oxygen	• Deny – convenience or precautionary supply
• Walker	• Covered, if patient meets Mobility Assistive Equipment clinical criteria (see § 280.3)

CMS Publications

Medicare Benefit Policy Manual, *(Internet-Only Manual Publ'n 100-02)* **Chapter 15, Section 110** sets forth the DME coverage guidelines.

Medicare Program Integrity Manual (MPIM) *(Internet-Only Manual Publ'n 100-08)* ***Chapter 5*** outlines some documentation requirements for DME.

Who Can Order DME? (1 of 3)

Treating Physician

Nurse Practitioner and Clinical Nurse Specialist, if they meet the following requirements:

a) Must treat the beneficiary for the condition for which the item is needed;

b) must practice independently of a physician;

Who Can Order DME? (2 of 3)

c) must have own provider number; and

d) must be authorized to order DME under State law.

Source: *MPIM*, Chapter 5, Sections 5.2.1 and 5.5

Who Can Order DME? (3 of 3)

Physician Assistant, if meet the following requirements:

a) Must treat the beneficiary for the condition for which the item is needed;

b) must practice under the supervision of a M.D. or D.O.;

Who Can Order DME? (3 of 3)

c) must have own provider number;

d) must be authorized to order DME under State law.

Source: *MPIM*, Chapter 5, Section 5.6

Definition of a Durable Medical Equipment

(Prior to January 1, 2012)

Under 42 C.F.R. § 414.202, "Durable Medical Equipment" is equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to an individual in the absence of an illness or injury; and
- Is appropriate for use in the home.

Definition of a Durable Medical Equipment

(Effective January 1, 2012) (1-2)

Under 42 C.F.R. § 414.202, "Durable Medical Equipment" is equipment that:

a) Can withstand repeated use;

b) Has an expected life of at least 3 years

c) Is primarily and customarily used to serve a medical purpose;

Definition of a Durable Medical Equipment

(Effective January 1, 2012) (2-2)

d) Generally is not useful to an individual in the absence of an illness or injury; and

e) Is appropriate for use in the home.

Coverage Requirements (1-2)

DME is covered under Medicare Part B if the following three requirements are met:

1. The equipment meets the definition of DME;

Coverage Requirements (2-2)

2. The equipment is reasonable and necessary for the treatment of an illness or injury or to improve the functioning of a malformed body member; and
3. The equipment is used in the patient's home.

Source: *MBPM*, Chapter 15, Section 110

Most Common Types of DME (1 of 2)

- Power Mobility Devices (**PMD**) such as power wheelchair or scooter
- Manual Wheelchairs, Walkers, Canes
- Hospital beds
- Oxygen equipment

Most Common Types of DME (2 of 2)

- Diabetic testing supplies
- High Frequency Chest Wall Oscillator (**HFCWO**) Vest
- Pneumatic compression device
- Negative Pressure Wound Therapy (**NPWT**) Pump
- Continuous Positive Airway Pressure (**CPAP**)

Certificate of Medical Necessity (1 of 4)

For certain DME items, the supplier must receive a **signed** Certificate of Medical Necessity (CMN) from the treating physician.

Examples

- CMS-484 CMN Form is for oxygen equipment
- CMS-846 CMN Form is for pneumatic compression device

Certificate of Medical Necessity (2 of 4)

- CMS-848 CMN Form is for transcutaneous electrical nerve stimulator (TENS)
- CMS-849 CMN Form is for seat lift mechanism

Certificate of Medical Necessity (3 of 4)

CMN contains Sections A through D.

- Sections A and C are completed by the supplier.
- Sections B and D are completed by the treating physician.

Certificate of Medical Necessity (4 of 4)

According to CMS, *MPIM,* chapter 5, Section 5.7, **a CMN alone is not sufficient** documentation to support payment of a DME.

DME Information Form (DIF)

Certain durable medical equipment requires DME Information Form (DIF).

Examples

- CMS-10125 DIF Form is for external infusion pumps.
- CMS-10126 DIF Form is for enteral and parenteral nutrition.

Physician Order

All durable medical equipment requires a physician's order, which must include a description of the item, the beneficiary's name, the physician's name, and the start date of the order.

Source: *MPIM*, Chapter 5, Section 5.2.2

Detailed Written Order (1-2)

- Certain durable medical equipment (e.g., power wheelchair) requires a **Detailed Written Order (DWO)**.

- Supplier may complete the detailed description of the item; however, the treating physician must review, sign, and date the order.

Detailed Written Order (2-2)

- Supplier must have a detailed written order prior to submitting a claim.

Source: *MPIM*, Chapter 5, Section 5.2.3

Face-to-Face Examination (1 of 2)

Certain durable medical equipment (e.g., oxygen equipment, hospital bed) requires a face-to-face examination by a physician, physician assistant, nurse practitioner, or a clinical nurse specialist with the beneficiary **within 6 months** prior to completing the order.

Source: *MPIM*, Chapter 5, Section 5.2.5

Face-to-Face Examination (2 of 2)

42 C.F.R. § 410.38(c)(2)(i) -

For **power mobility devices (PMD)** (e.g., power wheelchair, scooter), a physician, physician assistant, nurse practitioner, or a clinical nurse specialist must conduct a face-to-face examination of the beneficiary to determine medical necessity for the PMD as part of an appropriate overall treatment plan.

DME Replacements (1 of 2)

CMS, *MBPM*, chapter 15, Section 110.2C provides Medicare guidelines for DME replacement.

- **Reasonable Useful Lifetime (RUL)**
  Replacement due to wear is not covered during the reasonable useful lifetime of the equipment, which is usually 5 years.

DME Replacements (2 of 2)

- **Irreparable Damage** Equipment which the beneficiary owns may be replaced in cases of irreparable damage, which refers to a specific accident (e.g., car accident) or to natural disaster (e.g., flood, fire).

DME Repairs (1 of 2)

CMS, *MBPM*, chapter 15, Section 110.2A, provides Medicare guidelines for DME repair.

- During the reasonable useful lifetime of a DME (usually 5 years), Medicare will cover repair up to the cost of replacement for medically necessary equipment that is owned by the beneficiary.

DME Repairs (2 of 2)

- Repairs to equipment owned by beneficiary are covered when necessary to make the equipment serviceable.

Consolidated Billing Issues (1 of 5)

Consolidated billing issues arise when a Part B supplier bills for DME furnished to a beneficiary who is in a Part A hospital stay, or skilled nursing facility, or under a home health agency plan of care.

Consolidated Billing Issues (2 of 5)

Payment for medical supplies (e.g., wound care supplies) furnished during a Part A episode of care are generally included in the consolidated billing payment to the Part A provider, and separate payment to a supplier under Part B is prohibited by §§ 1862(a)(14), (18), and (21) of the Social Security Act.

Consolidated Billing Issues (3 of 5)

When a Part B supplier is denied payment, it typically requests a limitation on liability pursuant to § 1879 of the Social Security Act, or a waiver of the overpayment recovery pursuant to § 1870(b) of the Social Security Act.

Consolidated Billing Issues (4 of 5)

The Part B suppliers may argue that they are not at fault because they relied on third-party electronic systems to confirm that the beneficiary was not receiving Part A services before delivering the supplies at issue.

Consolidated Billing Issues (5 of 5)

CMS, *Medicare Claims Processing Manual (Internet-only Publ'n 100-04)* Chapter 10, Section 20.2, states that the "first avenue" for suppliers to pursue, is to ask the beneficiary (or his/her representative) if he or she is presently receiving home health services.

Prior Authorization (1-2)

- Final rule created **new** prior authorization requirements for certain DMEPOS items that are frequently subject to unnecessary utilization. 80 Fed. Reg. 81673 (Dec. 30, 2015).
- This list of DMEPOS is updated periodically.

Prior Authorization (2-2)

- Under the final rule, prior authorization is a condition of payment, so lack of prior authorization when required results in a claim denial. 42 C.F.R. § 414.234(c).
- Effective July 17, 2017, K0856 and K0861 are nationally subject to prior authorization. 81 Fed. Reg. 93636 (Dec. 21, 2016).

QIC's Most Common **Reasons** for Denial (1 of 2)

- Insufficient documentation
- No medical records
- Documentation did not describe beneficiary's functional limitations/physical deficits
- Record did not substantiate need for excessive quantities of supplies (e.g., diabetic testing supplies)

QIC's Most Common **Reasons** for Denial (2 of 2)

- Personal comfort item for beneficiary's convenience; not primarily medical in nature
- Beneficiary was in a SNF or hospital on the date of service
- No proof of delivery
- Another supplier is providing DME supplies to beneficiary

QIC's Most Common **Basis** for Denial

- Medicare coverage guidelines of the applicable LCD were not met.
- The documentation requirements of the applicable LCD were not met.

Module 13
Medicare Part B,
Outpatient Therapy Services

Lesson Objectives (1-2)

At the completion of this lesson, you will be able to:

1. Identify the statutes and regulations applicable to outpatient therapy services.

2. Understand Medicare coverage and payment rules for outpatient therapy.

3. Understand the difference between Maintenance Therapy and Rehabilitative Therapy.

Lesson Objectives (2-2)

4. Identify the documentation requirements for outpatient therapy services.

5. Understand how the yearly outpatient therapy cap functions.

Objective 1:

IDENTIFY THE LAWS AND REGULATIONS APPLICABLE TO APPEALS REGARDING OUTPATIENT SERVICES

Legal References

- Social Security Act (Act) § 1832(a)(2)(C)
- Act §§ 1861(p), 1861(g), 1861(ll), and 1861(s)(2)(D)
- Act §§ 1835(a)(1), 1835(a)(2)(C), and 1835(a)(2)(D)
- 42 C.F.R. §§ 410.59–410.62
- 42 C.F.R. § 424.24(c)
- CMS, *Medicare Benefit Policy Manual* (*MBPM*) (*Internet-Only Publ'n 100-02*) ch. 15, §§ 220-230.6
- CMS, *Medicare Claims Processing Manual* (*MCPM*) (*Internet-Only Publ'n 100-4*) ch. 10, §§ 10.2–10.6

Outpatient Therapy Services Benefit (1-2)

Outpatient therapy services are a covered benefit pursuant to § 1832(a)(2)(C) of the Act.

Outpatient therapy services under Medicare include Physical Therapy (Act § 1861(p)), Occupational Therapy (Act § 1861(g)), and Speech-Language Pathology Services (Act § 1861(ll)).

Outpatient Therapy Services Benefit (2-2)

Outpatient therapy services are distinct from Comprehensive Outpatient Rehabilitation Facility (CORF), which is a separately-defined benefit under section 1861(cc) of the Act. CORF services are governed by separate regulations, found at 42 C.F.R. §§ 410.100 through 410.105.

- It is important to distinguish the therapy coverage requirements in the CORF regulations from the general outpatient rehabilitation regulations.

Objective 2:

UNDERSTAND MEDICARE COVERAGE AND PAYMENT RULES FOR OUTPATIENT THERAPY

Conditions of Coverage (1-3)

MBPM, ch. 15, § 220.1 provides outpatient therapy services are payable only when furnished in accordance with the following three conditions:

- Services are or were required because the individual needed therapy services;
- A plan for furnishing such services has been established by a physician or Non-Physician Practitioner (NPP) or by the therapist providing such services and is periodically reviewed by a physician/NPP;
- Services are or were furnished while the individual is or was under the care of a physician;

Conditions of Coverage (2-3)

- In certifying an outpatient plan of care for therapy a physician/NPP is certifying that the above three conditions are met. 42 C.F.R. § 424.24(c).
  - Certification is required for coverage and payment of a therapy claim.

- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the National Provider Identifier (NPI) of the certifying physician identified for a PT, OT, and SLP plan of care. This requirement is effective for claims with dates of service on or after October 1, 2012. *MCPM,* ch. 5, § 10.3.

Conditions of Coverage (3-3)

- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the required functional reporting. *MCPM,* ch. 5, § 10.6.

- The patient functional limitations(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care and expressed as part of the patient's long term goals. *MCPM,* ch. 5, § 10.6.

Reasonable and Necessary Criteria (1-3)

Pursuant to *MBPM*, chapter 15, section 220.2(B), for therapy services to be reasonable and necessary, the following conditions must each be met:

1. The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

   - Acceptable practices for therapy services are found in Medicare manuals, Contractors' Local Coverage Determinations, and guidelines and literature of the professions of physical therapy, occupational therapy, and speech-language pathology.

Reasonable and Necessary criteria (2-3)

2. The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such, that the services required can be safely and effectively performed only by a therapist; or in the case of physical therapy and occupational therapy, by or under the supervision of a therapist; and

   - Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from therapy, but rather on the beneficiary's need for skilled care.

Reasonable and Necessary Criteria (3-3)

3. While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled.

4. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals, or the state/national therapy associations, in the development of any utilization guidelines.

Medicare Payment

42 C.F.R. § 424.24 requires a physician to certify the need for therapy. The physician's certification must set forth that:

- The individual needs, or needed, physical therapy or speech-language pathology services.
- The services were furnished while the individual was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
- The services were furnished under a plan of treatment that meets the requirements of 42 C.F.R. § 410.61.

Objective 3:

UNDERSTAND THE DIFFERENCE BETWEEN REHABILITATIVE THERAPY AND MAINTENANCE THERAPY

Rehabilitative Therapy

- **Rehabilitative therapy** addresses recovery or improvement in function and, when possible, restoration to a previous level of health and well-being.

- If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

MBPM, ch. 15, § 220.2(C).

Maintenance Programs

- Skilled therapy services may be covered in certain circumstances as maintenance therapy.
- The goal of a **maintenance therapy program** would be, for example, to maintain functional status or to prevent or slow further deterioration in function.
- The maintenance program provisions outlined in *MBPM*, ch. 15, § 220.2(D) do not apply to PT, OT, or SLP services furnished in a CORF because the statute specifies that CORF services are rehabilitative.

MBPM, supra ch. 15, § 220.2(D).

Jimmo v. Sebelius

On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, involving skilled nursing and skilled therapy services in the skilled nursing facility, home health, and outpatient therapy settings.

Jimmo v. Sebelius

The settlement agreement is intended to **clarify** that, when skilled nursing or skilled therapy services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, **coverage cannot be denied based on the absence of potential for improvement or restoration**.

Coverage is not available when the beneficiary's care needs can be met safely and effectively through the use of nonskilled personnel.

Skilled Care

In evaluating a claim for skilled care where the **treatment goal is maintenance**, skilled nursing or therapy services are covered where such services are necessary to maintain the patient's current condition or prevent or slow further deterioration.

In evaluating a claim for skilled services that are **rehabilitative** in nature, it would be appropriate to consider the beneficiary's potential for improvement from the services.

See CMS, *Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet,* at *https://www.cms.gov/medicare/medicare-fee-for-service-payment/snfpps/downloads/jimmo_fact_sheet2_022014_final.pdf*.

Objective 4:

UNDERSTAND THE DOCUMENTATION REQUIREMENTS FOR OUTPATIENT THERAPY SERVICES

Outpatient Therapy Documentation Requirements

1. Evaluation and Plan of Care
2. Certification and Re-certifications
3. Progress Reports
4. Treatment Notes

Plan of Care Requirements (1-4)

- The plan MUST include, at a minimum:
  - The diagnoses
  - Long term treatment goals
  - And identify the:
    1) Type;
    2) Amount;
    3) Duration; and
    4) Frequency of therapy services to be furnished.

MBPM, *supra* ch. 15, § 220.1.2(B).

Plan of Care Requirements (2-4)

An outpatient therapy plan of treatment must be in writing and established by a qualified medical professional (physician, physical therapist, speech-language pathologist, occupational therapist, nurse practitioner, a clinical nurse specialist, or a physician assistant).

The plan must be established prior to the start of therapy.

Act § 1861(p)(2); 42 C.F.R. § 410.61(b)(2); *MBPM*, *supra* ch. 15, § 220.1.2.

Plan of Care Requirements (3-4)

Changes made to the initial plan of care must be:

- Made in **writing and signed** by a qualified medical professional.
  - Qualified medical professional includes a registered professional nurse or a staff physician acting in accordance with oral orders from the physician or physical therapist, speech-language pathologist, or occupational therapist who is furnishing the services.
- Incorporated into the plan immediately.

42 C.F.R. § 410.61(d)(1)–(2).

Plan of Care Requirements (4-4)

The plan of care may also include:

- Short term goals
- Goals and duration for the current episode of care
- Specific treatment interventions
- Procedures
- Modalities and techniques and the amount of each

Physician Certification of the Plan of Care

Physician Certification of the Plan of Care is required:

- Certifications are required for each interval of treatment based on the patient's needs, **not to exceed 90 calendar days** from the initial therapy treatment.
- The **signature and professional identity** (e.g., MD, OTR/L) of the person who established the plan, **and the date** it was **established** must be recorded with the plan.
- Certifications are timely when the initial certification (or certification of a significantly modified plan of care) is dated **within 30 calendar days of the initial treatment under that plan**.
- **Certification requires a dated signature** on the plan of care or some other document that indicates approval of the plan of care.

MBPM, supra ch. 15, § 220.1.3.

Recertification of the Plan of Care

Recertification is timely when dated during the duration of the initial plan of care or within 90 calendar days of the initial treatment under that plan, whichever is less.

MBPM, *supra* ch. 15, § 220.1.3.

Delayed Certification

It is not intended that needed therapy be stopped or denied when certification is delayed.

The delayed certification of otherwise covered services **should be accepted unless the contractor has reason to believe that there was no physician involved in the patient's care**, or treatment did not meet the patient's need (and therefore, the certification was signed inappropriately).

MBPM, supra ch. 15, § 220.1.3(D).

Lack of Certification (1-3)

If there is a lack of certification, then it would be a technical denial, which means a statutory requirement has not been met.

Limitation on Liability provisions of § 1879 of the Act do not apply to the technical denial.

MBPM, *supra* ch. 15, § 220.1.3(E).

Lack of Certification (2-3)

Beneficiary liability for technical denial for lack of certification:

- If the service is provided by a **supplier** (individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers), the beneficiary would be held liable.

MBPM, *supra* ch. 15, § § 220(A) and 220.1.3.

Lack of Certification (3-3)

Beneficiary liability for technical denial for lack of certification:

- A **provider** (hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, or a comprehensive outpatient rehabilitation facility) is precluded from charging the beneficiary for services denied as a result of a missing certification under 42 C.F.R. § 489.21.

MBPM, *supra*, ch. 15, § 220.1.3.

Progress Reports (1-2)

The minimum progress report period shall be at least once every 10 treatment days.

Progress reports written by a clinician shall include:

- Assessment of improvement, extent of progress (or lack thereof) toward each goal;
- Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's progress report;

Progress Reports (2-2)

- Changes to long or short term goals, discharge or an updated plan of care that is sent to the physician/NPP for certification of the next interval of treatment; and

- Functional documentation is required as part of the progress report at the end of each progress reporting period. It is also required at the time of discharge on the discharge note or summary, as applicable.

Note: A separate justification statement may be included, however, is not required if the record justifies treatment without further explanation.

Treatment Notes (1-2)

Treatment notes are required for each treatment day.

Documentation of each treatment shall include the following required elements:

- Date of treatment;
- Identification of each specific intervention/modality provided and billed, for both timed and untimed codes;

Treatment Notes (2-2)

- Total timed code treatment minutes and total treatment time in minutes; and

- Signature and professional identification of the qualified professional who furnished or supervised the services and a list of each person who contributed to the treatment.

MBPM, *supra* ch. 15, § 220.3(E).

Objective 5:

UNDERSTAND HOW THE YEARLY OUTPATIENT THERAPY CAP FUNCTIONS

Outpatient Therapy Cap (1-3)

- Medicare imposes a monetary limit (cap) on the amount of covered outpatient therapy a Medicare beneficiary may receive each year.
- The outpatient therapy cap for calendar year 2017 is $1,980 for physical and speech-language pathology combined and $1,980 for occupational therapy.
- The cap is not based upon the beneficiary's out-of-pocket expense. Medicare determines whether the cap is reached by adding the amount Medicare has paid plus the Part B deductible ($183 per year for 2017) and coinsurance.

Outpatient Therapy Cap (2-3)

- If a beneficiary reaches the yearly outpatient therapy cap and still requires therapy, Medicare will pay under an exception process if the therapy is found to be **medically necessary**. The therapist will have to provide medical documentation to demonstrate that continued outpatient therapy is required.

- In billing for therapy in excess of the cap, a therapy provider must add a KX modifier to a claim to attest that above-the-cap therapy is medically necessary for a beneficiary.

MCPM, *supra* ch. 5, §§ 10.2–10.3.

Outpatient Therapy Cap (3-3)

- The Bipartisan Budget Act of 2018 **repealed** therapy cap for services provided on or after January 1, 2018.
- CMS will be providing further guidance on how this provision affects coverage of outpatient therapy services in the future.

Therapy Caps and Liability

- Prior to January 1, 2013, claims for therapy services in excess of the therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable.
- Section 603(c) of the American Taxpayer Relief Act of 2012 amended §1833(g)(5) of the Act to provide limitation on liability provisions to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are provided in excess of therapy cap amounts and do not qualify for an exception.
- The provider or supplier must issue a valid, mandatory Advance Beneficiary Notice of Noncoverage (ABN) to the beneficiary before providing services above the cap when the therapy coverage exceptions process is not applicable.

MCPM, supra ch. 5, § 10.5.

Summary

Now that you have completed this lesson, you should be able to:

- ✓ Identify the laws and regulations applicable to appeals regarding outpatient services.
- ✓ Identify the types of outpatient therapy available.
- ✓ Discuss and analyze Medicare coverage and payment requirements for outpatient therapy.
- ✓ Understand the outpatient therapy documentation requirements.
- ✓ Understand how the yearly outpatient therapy cap functions.

Module 14:
Medicare Advantage (Part C)

Objectives

At the completion of this lesson, you will be able to:

- Understand the background of Medicare Part C;
- Identify the types of issues found in Part C cases;
- Recognize how the Part C appeals process differs from the appeals process for Parts A and B;
- Understand the difference between an appeal and a grievance; and
- Identify what a Part C Plan covers and what it does not cover.

Types of Medicare Plans

- Medicare Part A – Hospital Insurance
- Medicare Part B - Supplementary Medical Insurance (SMI)
- Medicare Part C – Medicare Advantage (MA) Plans
- Medicare Part D – Prescription Drug Coverage
- Medigap or Medicare Supplemental Insurance

So what is a Medicare Advantage plan?

Medicare Advantage plans are a type of Medicare health plan that are administered and run by private insurers that contract with Medicare to provide an individual with all of their Part A and Part B basic benefit.

Some Key Aspects of Medicare Advantage

- MA Organizations (MAOs) receive a capitated rate of reimbursement per beneficiary member.
- Availability of supplemental and/or Part D benefits
- Out of Pocket Spending Caps
- Network Providers
- Limitations on out-of-area care
- Enrollment/Disenrollment

Medicare Advantage Options

- Coordinated Care Plans
- Medicare Medical Savings Accounts
- Private Fee-for-Service Plans
- Specialized Medicare Advantage Plans for Special Needs Individuals (SNP)

Eligibility

Eligible Persons

- To be eligible for an MA plan, an individual must be entitled to benefits under Part A and enrolled in Medicare Part B, and not have End Stage Renal Disease.

Eligibility

Persons Ineligible to Enroll

- Qualified Medicare Beneficiary
- Specified Low Income Beneficiary
- Qualified Disabled and Working Individual

Coordination of Enrollment & Disenrollment

The enrollment and disenrollment of an individual in a MA plan of a MA organization is governed by the election of coverage under MA plans.

Coordination of Enrollment & Disenrollment

An individual may elect a different MA plan by filing the appropriate election with the MA; or submit a request for disenrollment to the MA in the form and manner prescribed by CMS, or file the appropriate disenrollment form through other mechanisms as determined by CMS.

Enrollment/Disenrollment Periods

- Initial coverage election
- Annual election period
- Special Election periods
- 45-Day Medicare Advantage Disenrollment Period

Evidence of Coverage

MA Plans are required to clearly communicate to enrollees through Evidence of Coverage (EOC) and Summary of Benefits -

- the MA plan's service area,
- The benefits offered under the plan including premiums and cost-sharing, and
- Information related to access to services.

Appeal and Grievance

MA appeal procedures include an internal grievance process and a formal appeal process with external review.

- **Grievances** involve issues about the quality of services received, the time and location of services and related matters.
- **Appeals** address concerns and disagreements with organizational determinations (i.e., whether an item, service or procedure is covered)

Grievance Process

Medicare requires an internal process for reviewing grievances.

A grievance is:

> any complaint or dispute, other than one that constitutes an organization determination, which expresses dissatisfaction with any aspect of the MA Organization's or provider's operations, activities or behavior regardless if remedial action is requested.

Appeals Process

An **appeal** is defined as any of the procedures that deal with the review of adverse **organization determinations** related to:

- Basic benefits
- Mandatory and optional supplemental benefits
- Amount, if any, the beneficiary is to pay

The regulations governing the appeals process for organization determinations are found at 42 C.F.R. §§ 422.566 through 422.626.

Appeals Process

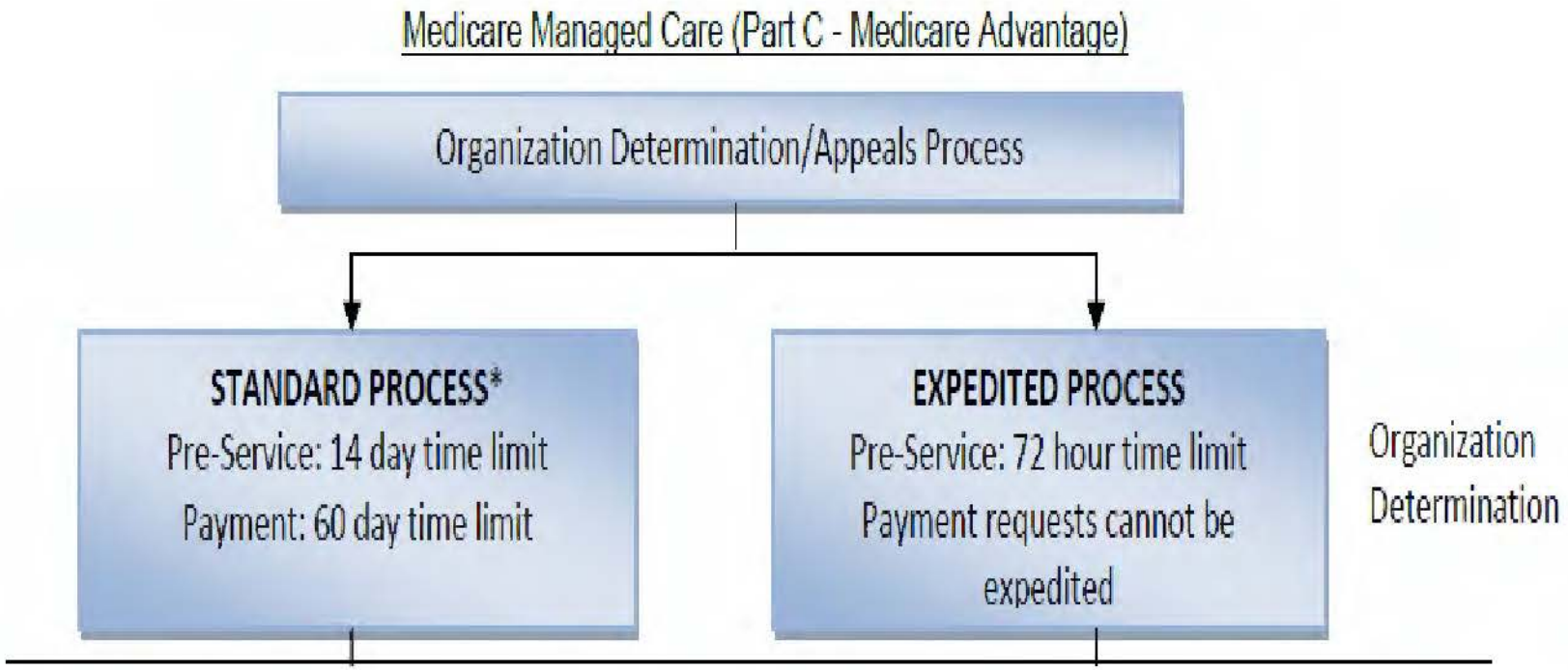
Medicare Advantage has a standard and an expedited process for handling appeals.

A special expedited review process applies when an MA plan terminates pre-authorized coverage of an inpatient hospital admission or Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility services.

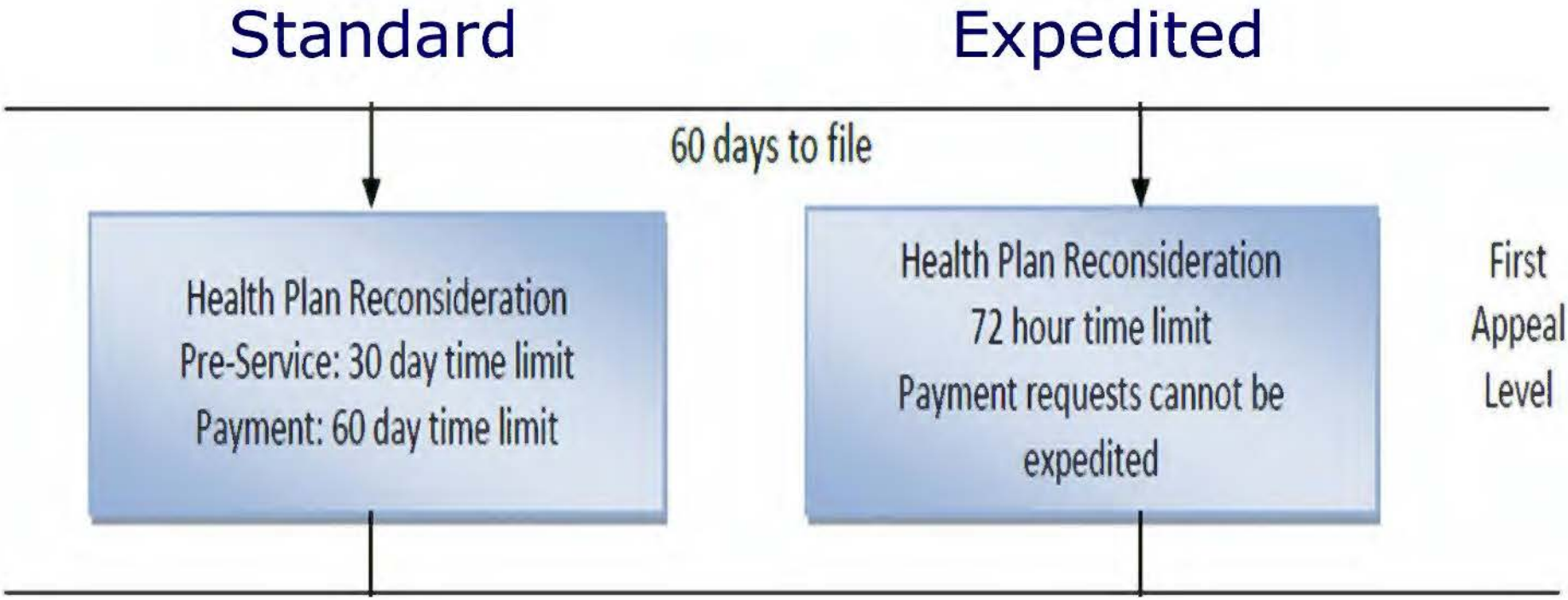
Appeals Process

Expedited review requests filed timely bypass the MA plan's reconsideration process, and an independent review entity known as a Quality Improvement Organization (QIO) performs the review.

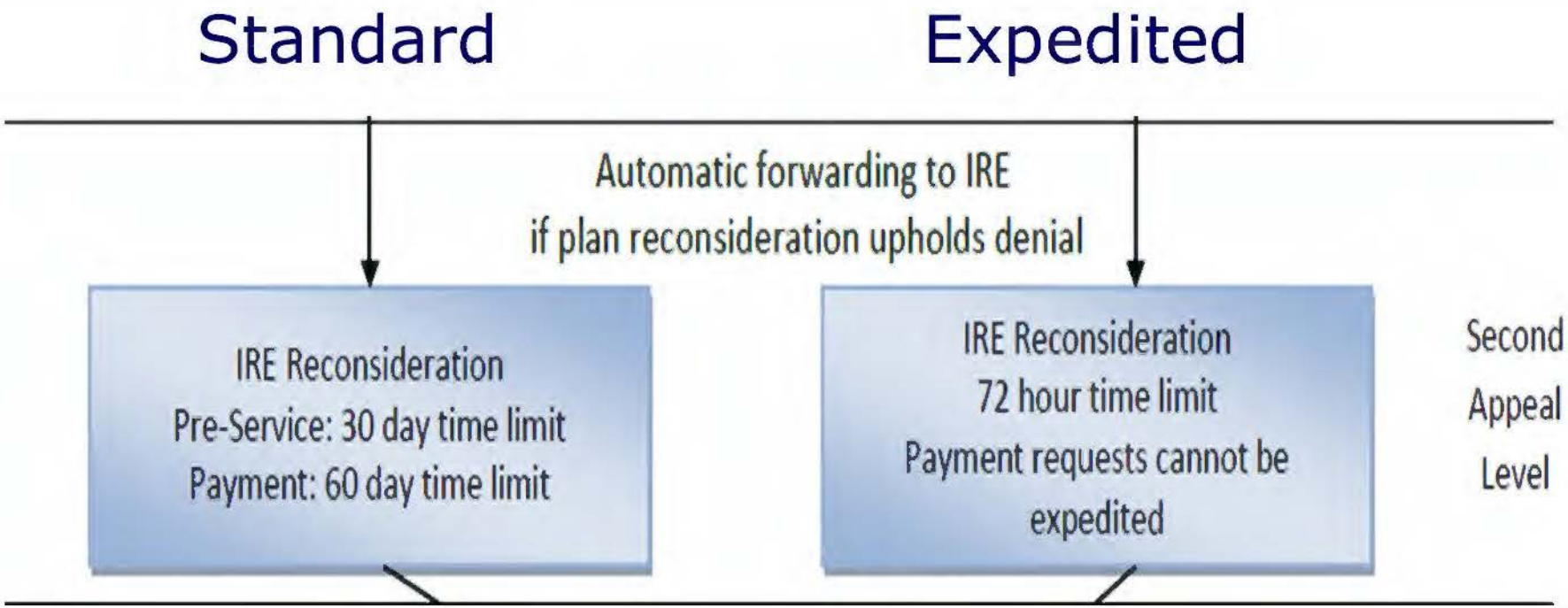
Appeals Process



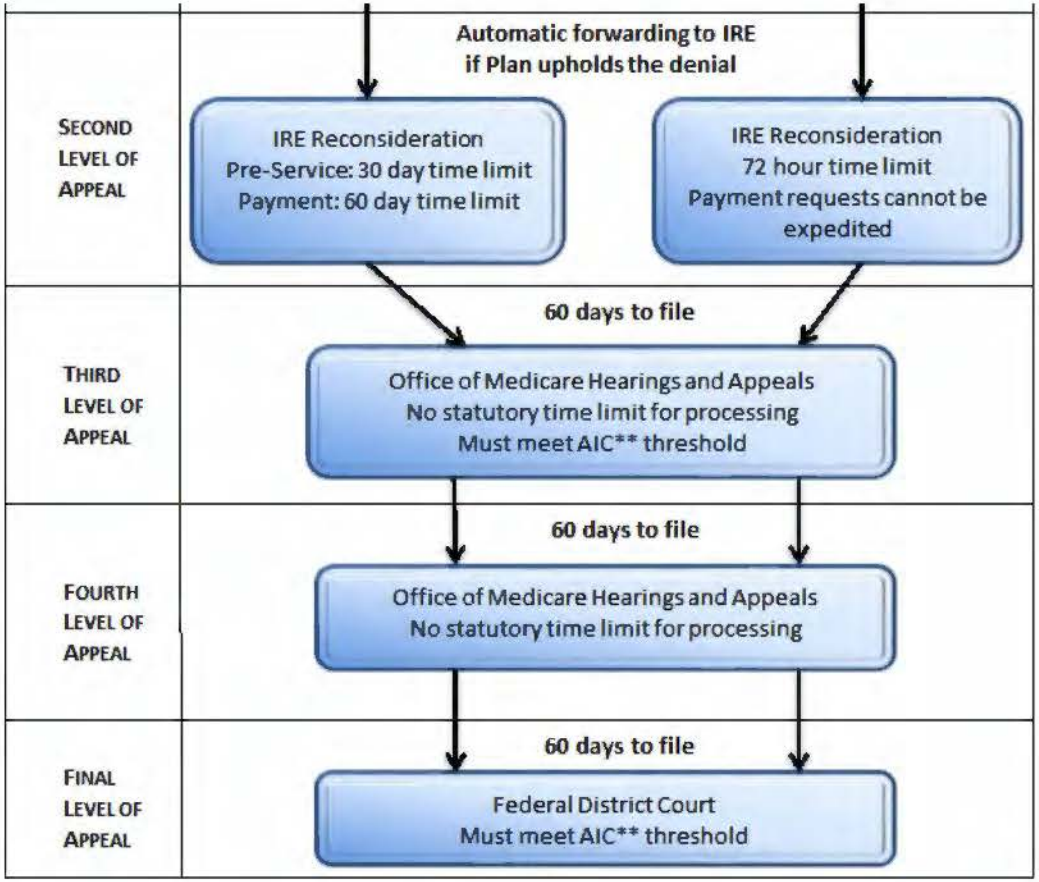
Appeals Process



Appeals Process



Appeals Process



AIC = Amount in Controversy/ ALJ = Administrative Law Judge/ IRE = Independent Review Entity

*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be process within 60 days

**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.

Hospital Discharge Appeal Rights

- Hospitals must deliver valid, written notice to an enrollee of their rights as a hospital inpatient including their discharge appeal rights.
- Before discharging an enrollee, MA organization must obtain concurrence from the physician who is responsible for the enrollee's inpatient care.
- Enrollee has a right to immediate QIO review and other appeal processes if the enrollee fails to meet the deadline for immediate review.

Termination of Provider Services

- Termination of service is the discharge of an enrollee from covered provider services, or the discontinuation of covered provider services, when the enrollee has been authorized by the MA plan to receive an ongoing course of treatment from that provider.
- Valid, timely notice is required.
- Enrollee has a right to a fast-track appeal of an MAO decision to terminate provider services to the Independent Review Entity.

Types of Organization Determinations

- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment.
- Failure of the MAO to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide enrollee with timely notice of adverse determination.

Types of Organization Determinations

- Payment for temporary out of area renal dialysis services, emergency services, post-stabilization care or urgent care.
- Payment for any other health services furnished by a non-MA provider that the enrollee believes are covered under Medicare or if not covered under Medicare should be covered under the MA plan.
- Refusal to provide or pay for services in whole or in part, including the type of level of services, that enrollee believes should be furnished or arranged for by the MA.

Special Rules

- Ambulance Transportation
  - 42 C.F.R. § 422.113(a)
- Emergency and Urgently Needed Services
  - 42 C.F.R. § 422.113(b)
- Maintenance Care and Post-Stabilization Care Services
  - 42 C.F.R. § 422.113(c)

Hospice

Hospice - Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan.

Liability

- Section 1879 of the Social Security Act does not apply in MA cases.
- But there are protections including the hospital discharge notices, and termination of provider services notices discussed earlier.

Resources

- 42 C.F.R. Part 422
- CMS, *Medicare Managed Care Manual (Internet-Only Manual Publ'n 100-16)*.
- NCDs and LCDs

Summary

Now that you have completed this lesson, you should now be able to:

- ✓ Understand the background of Medicare Part C;
- ✓ Identify the types of issues found in Part C cases;
- ✓ Recognize how the Part C appeals process differs from the appeals process for Parts A & B;
- ✓ Understand the difference between an appeal and a grievance; and
- ✓ Identify what a Part C Plan covers and what it does not cover.

Module 15 - Liability

Liability Objectives

At the completion of this lesson you will be able to:

- ✓ Understand the issues surrounding liability determinations in Medicare appeals.
- ✓ Understand the role of notice within liability determinations in Medicare appeals.

Section 1879 of the Social Security Act (Act)

Section 1879 of the Act (1-8)

In addition to other, more limited instances, section 1879 of the Act applies to Medicare claims that are denied pursuant to section 1862(a)(1)(A) of the Act because the items or services were not medically reasonable and necessary.

Section 1879 of the Act (2-8)

Section 1879 of the Act does not apply to claims denied because the technical requirements for Medicare coverage or payment were not met.

Section 1879 of the Act (3-8)

The threshold issue in determining liability and payment is:

Knowledge

Did anybody related to this claim have knowledge that it might not be covered by Medicare?

Section 1879 of the Act (4-8)

42 C.F.R. § 411.404

A beneficiary is considered to know that services are not covered by Medicare if a written notice of no coverage is given to the beneficiary or someone acting on the beneficiary's behalf.

Section 1879 of the Act (5-8)

42 C.F.R. § 411.406

The criteria for determining if a provider or a supplier knew or should have known that Medicare would not pay for a service or item.

Knowledge may be based on experience, actual notice, or constructive notice.

Section 1879 of the Act (6-8)

Knowledge is established by:

- Receipt of CMS notices, including manual issuances, bulletins, or other written guides or directives from Medicare Administrative Contractors (MACs) or Quality Improvement Organizations (QIOs)

Section 1879 of the Act (7-8)

Knowledge is established by:

- Federal Register publications containing notice of national coverage decisions or of other specifications regarding non-coverage of an item or service

Section 1879 of the Act (8-8)

Knowledge is established by:

- The provider or supplier's knowledge of what are considered acceptable standards of practice by the local medical community.

42 C.F.R. § 411.406(e)(1) – (3)

HCFA Ruling 95-1-18

Medicare Manual

Medicare Claims Processing Manual (MCPM) (Internet-Only Manual Publ'n 100-04) ch. 30, Financial Liability Protections

- Secs. 20.1-20.1.1 – Coverage denials to which limitation on liability applies
- Secs. 20.2-20.2.2 – Denials to which limitation on liability does NOT apply (technical denials)
- Sec. 40.2.1 – beneficiary knowledge standards
- Sec. 40.2.4 – other evidence of knowledge

Advance Beneficiary Notices

Advance Beneficiary Notices (1-4)

To be effective, an Advance Beneficiary Notice of Noncoverage (ABN) must do more than simply state that payment might not be made.

Advance Beneficiary Notices (2-4)

HCFA Ruling 95-1:

"…in accordance with § 411.404, a written notice of Medicare denial of payment must contain sufficient information to enable the beneficiary to understand the basis for the denial."

Advance Beneficiary Notices (3-4)

Contain such specificity to permit the beneficiary to be able to obtain evidence in rebuttal of the denial, and clearly give the beneficiary the option to elect to receive an item or service (for which they will be financially responsible) or to refuse the item or service and waive their right to appeal its denial.

Advance Beneficiary Notices (4-4)

Allow beneficiary to make "informed consumer decisions." *MCPM, supra* ch. 30, § 40.3.

Generic ABN (1-2)

Generic Notice (for provider service terminations)

Requirements - 42 C.F.R. § 405.1200:

1) The date that coverage of services ends;
2) The date that the beneficiary's financial liability for continued services begins;
3) A description of the beneficiary's right to an expedited determination;

Generic ABN (2-2)

4) A beneficiary's right to receive the detailed information;

5) Any other information required by CMS; and

6) The date and signature of the beneficiary, or an authorized representative.

SNFABN

Requirements - there must be a lay language explanation as to why the services will be denied, a specification of the services that Medicare is expected not to pay, and the reason Medicare is unlikely to pay.

MCPM, supra ch. 30, § 70.1

1879 Decision Tree

Section 1879 of the Act— Decision Process (1-8)

1) Was the item or service denied as not "reasonable and necessary" and related to:

- The diagnosis or treatment of an illness or injury - Act § 1862(a)(1)(A);
- Improvement of the function of a malformed body member – *Id;*
- The prevention of illness – Act § 1862(a)(1)(B);

Section 1879 of the Act— Decision Process (2-8)

- Hospice, the palliation or management of a terminal illness – Act § 1862(a)(1)(C);
- The conduct of a clinical research study – Act § 1862(a)(1)(D);
- The conduct of a health service research study – *Id.*

Section 1879 of the Act— Decision Process (3-8)

2) Were the denied services home healthcare?

3) Were the denied services custodial care?

4) Were the denied services hospice care?

Section 1879 of the Act— Decision Process (4-8)

5) Did the beneficiary receive any of the following items or services more frequently than indicated, or earlier than they should be provided?

- Screening mammograms, pap smears, pelvic exams, or glaucoma tests - Act § 1862(a)(1)(F)

Section 1879 of the Act— Decision Process (5-8)

- Prostate cancer screening exams – Act § 1862(a)(1)(G)
- Colorectal cancer screening exams – Act § 1862(a)(1)(H)
- Home health services (frequency or duration) – Act § 1862(a)(1)(I)

Section 1879 of the Act— Decision Process (6-8)

5) Did the beneficiary receive any of the following items or services more frequently than indicated, or earlier than they should be provided?

- Drugs or biologicals purchased under a contract not approved under HHS competitive bidding process - Act § 1862(a)(1)(J)

Section 1879 of the Act— Decision Process (7-8)

- Initial Part B preventative physical exam – Act § 1862(a)(1)(K)
- Cardiovascular screening blood tests – Act § 1862(a)(1)(L)
- Diabetes screening blood tests – Act § 1862(a)(1)(M)

Section 1879 of the Act— Decision Process (8-8)

6) **STOP**!!

§ 1879 IS NOT A FACTOR IN THE DECISION.

7) You must consider § 1879.

IMPORTANT! If payment is denied for any item or service NOT considered in the decision process document, § 1879 DOES NOT APPLY, and cannot be used to limit liability.

Section 1879 of the Act - Payment

1) If neither the provider/supplier nor beneficiary had knowledge of non-coverage, the claim can be paid.

2) If either the provider/supplier or beneficiary had knowledge of non-coverage, the claim cannot be paid.

Section 1879 of the Act - Liability

1) If the provider/supplier had knowledge of non-coverage and beneficiary did not, provider/supplier is liable.

2) If the beneficiary had knowledge of non-coverage, the beneficiary is liable.

Section 1870 of the Act

Section 1870 of the Act (1-6)

Section 1870 of the Act provides for waiver of recovery of overpayments (post-payment coverage denials).

Section 1870 of the Act (2-6)

Medicare cannot recover overpayments when, generally:

- The provider/supplier is not "at fault" in creating the overpayment;
- Recovery is against equity and good conscience; and
- Recoupment is an offset for a party not "at fault."

Section 1870 of the Act (3-6)

Relation to section 1879 of the Act

- In an overpayment appeal, section 1879 of the Act MUST be considered prior to any consideration of section 1870.
- For example, if coverage is denied, and liability is limited under section 1879 of the Act, there would be no resultant overpayment and no section 1870 analysis.

Section 1870 of the Act (4-6)

1870(b) – For providers and suppliers

1870(c) – For beneficiaries

Section 1870(b) of the Act (5-6)

For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, **in the absence of evidence to the contrary,** be deemed **to be without fault** if the Secretary's determination that more than such correct amount was paid was made **subsequent to the fifth year following the year in which notice was sent to such individual that such amount had been paid**; except that the Secretary may reduce such five-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

Section 1870(c) of the Act (6-6)

There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) **with respect to an individual who is without fault** or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), **if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience.**

Section 1834 of the Act

Section 1834 of the Act (1-2)

Act § 1834(j)(4) – Non-participating suppliers are responsible for the costs of DMEPOS furnished without a valid supplier number.

Section 1834 of the Act (2-2)

Act § 1834(a)(18) – Beneficiary is entitled to timely refund of amounts paid to such an entity, unless:

- The supplier did not know and could not reasonably have been expected to know that payment may not be made; or
- Before the item was furnished, the beneficiary was informed that payment may not be made and still agreed to receive and pay for the item.

Other

Ambulance Exception

Typically a technical denial under Act § 1861(s)(7).

Limitation on Liability only applies when payment is fully or partially denied as not "reasonable and necessary," for example:

- Air Transport was provided when Ground Transport would have sufficed; or
- A level of care downgrade, e.g., from Advanced Life Support to Basic Life Support.

Summary

Now that you have completed this lesson, you should be able to:

- ✓ Understand the issues surrounding liability determinations in Medicare appeals.
- ✓ Understand the role of notice within liability determinations in Medicare appeals.