Welcome and Update
ALJ Hearing Process

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

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

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

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

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

Office of Programs
---------------
Budget & Financial Mgmt
Executive Support & Resources
Information Management & Systems
Program Evaluation & Policy

Field Operations
Central Operations

Office of Operations

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

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

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

Kansas City Field Office
Kansas City, MO
----------
Associate Chief Administrative Law Judge
----------
Hearing Office Director

Miami Field Office
Miami, FL
----------
Associate Chief Administrative Law Judge
----------
Hearing Office Director
Types of Appeals

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

Receipts by Medicare Type

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Dispositions</th>
<th>Dispositions without Dismissals</th>
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<tbody>
<tr>
<td>FY09</td>
<td>2.2</td>
<td>1.9</td>
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<tr>
<td>FY10</td>
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<td>FY11</td>
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<td>4.9</td>
<td>3.7</td>
</tr>
<tr>
<td>FY14</td>
<td>6.0</td>
<td>4.2</td>
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</table>

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

*The FY14 receipts are based on estimated receipts through June 2014.
Received appeals represents cases with Request for Hearing Date in listed year.
Decided appeals represents cases decided in listed fiscal year no matter what year case was received.
Excludes Remands, Reopened and Combined Appeals.
Receipts may be incomplete due to data entry backlog.
FY14 Data as of September 30, 2014

Receipt data corrected from original presentation

Run Date: November 13, 2014
OMHA Workload

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

<table>
<thead>
<tr>
<th></th>
<th>FY09</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>FY14 YTD</th>
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<tr>
<td>Appeals</td>
<td>32,732</td>
<td>42,072</td>
<td>53,775</td>
<td>79,443</td>
<td>193,159</td>
<td>227,000</td>
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<tr>
<td>RAC</td>
<td>195</td>
<td>198</td>
<td>1,830</td>
<td>7,294</td>
<td>23,680</td>
<td>20,000</td>
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<tr>
<td>Traditional</td>
<td>2,904</td>
<td>2,091</td>
<td>3,995</td>
<td>20,000</td>
<td>150,000</td>
<td>148,000</td>
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<tr>
<td>MSA</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
</tr>
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</table>

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

- Represents cases with Request for Hearing Date in listed year
- Excludes reopened and combined appeals
- FY14 receipts may be incomplete due to data entry backlog.

Run Date: November 13, 2014
OMHA Workload

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

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

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

- **Beneficiary-initiated appeals**
  - 109.3 Days APT
  - 9,718 beneficiary appeals assigned (since July 15, 2013)
  - Number of decided since priority implemented, 7,879 as of September 30, 2014

- Expedited Part D Appeals still receive immediate attention
### Effect of Workload – Avg Processing Time

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Days</th>
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<tbody>
<tr>
<td>FY09</td>
<td>94.9</td>
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<td>FY11</td>
<td>121.3</td>
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<td>FY12</td>
<td>134.5</td>
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<td>FY13</td>
<td>220.7</td>
</tr>
<tr>
<td>FY14</td>
<td>414.8</td>
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<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Days</th>
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<tbody>
<tr>
<td>October</td>
<td>301.3</td>
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<tr>
<td>November</td>
<td>325.8</td>
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<tr>
<td>December</td>
<td>343.7</td>
</tr>
<tr>
<td>January</td>
<td>371.0</td>
</tr>
<tr>
<td>February</td>
<td>383.3</td>
</tr>
<tr>
<td>March</td>
<td>402.4</td>
</tr>
<tr>
<td>April</td>
<td>418.7</td>
</tr>
<tr>
<td>May</td>
<td>441.4</td>
</tr>
<tr>
<td>June</td>
<td>463.2</td>
</tr>
<tr>
<td>July</td>
<td>488.7</td>
</tr>
<tr>
<td>August</td>
<td>495.5</td>
</tr>
<tr>
<td>September</td>
<td>514.5</td>
</tr>
</tbody>
</table>

**FY14 Average** 414.8
OMHA Initiatives

- Expansion of adjudication capacity
  - Kansas City Field Office

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

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

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

<table>
<thead>
<tr>
<th>SELECT Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Appeal Number (Reconsideration)</td>
<td>1-0555-00</td>
</tr>
<tr>
<td>ALJ Appeal Status</td>
<td>Assigned</td>
</tr>
<tr>
<td>ALJ Appeal Number</td>
<td>1-1001-00</td>
</tr>
<tr>
<td>Request for ALJ Hearing Received Date</td>
<td>05/18/2013</td>
</tr>
<tr>
<td>ALJ Hearing Date</td>
<td>Miami</td>
</tr>
<tr>
<td>ALJ Decision Mailed Date</td>
<td>Miami</td>
</tr>
<tr>
<td>ALJ Hearing Office</td>
<td>Miami</td>
</tr>
<tr>
<td>Administrative Law Judge</td>
<td>Lauren Heard</td>
</tr>
<tr>
<td>ALJ Team Phone Number/Extension</td>
<td>305-615-7449</td>
</tr>
<tr>
<td>Notes</td>
<td>This appeal has been assigned, and will be reviewed by the Administrative Law Judge indicated above.</td>
</tr>
</tbody>
</table>

### Hearing Office(s)

<table>
<thead>
<tr>
<th>State</th>
<th>Office</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miami</td>
<td>OCMH Southern Field Office</td>
<td>100 SE 2nd St., Suite 1660, Miami, FL 33131-2109</td>
<td>866-622-0362</td>
</tr>
</tbody>
</table>

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

• Development Contract Award Date – January 2015

• Release I- Fall 2015 (October)
  ▪ Case intake
  ▪ Appellant Public Portal (Phase I)
    ▪ Electronic filing of Request for Hearing
    ▪ Submission of electronic evidence

• Release II-Spring 2016 (May)
  ▪ The appeal adjudication process from ALJ assignment to closure

• Release III - Fall 2016 (November)
  ▪ Enhanced Appellant Public Portal (Phase II)
    ▪ Allows authenticated parties to view files electronically
    ▪ Communication to and from OMHA
Contract Scanning Initiative

- Scan all unassigned Request for Hearings and associated documents
  - Transition to ECAPE
- Expected Implementation- December 2014
How Appellants will be Affected

- Case processing efficiencies
- Accessibility through the Portal will allow:
  - Electronic filing of Request for Hearing
  - Submission of electronic evidence
  - Authorized parties to view their file electronically
  - Communication to and from OMHA
What You Can Do to Help Reduce Processing Times

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

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

QUESTIONS
COME LATER
OMHA Initiatives

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

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

- Pilot criteria on OMHA website:
  www.hhs.gov/omha/settlement_conference_facilitation_pilot.html

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

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>General Information</strong> This spreadsheet requests the data needed by the Centers for Medicare &amp; Medicaid Services to evaluate your claims for settlement conference. Electronic submission of the SCF Spreadsheet via CD is required; however, submitting your entire request package via CD is strongly encouraged. The spreadsheet must be submitted as a Microsoft Excel spreadsheet (please do not submit a PDF document of the information requested in this spreadsheet). <strong>NOTE:</strong> One spreadsheet per CMS Certification Number (CCN) or Provider Transaction Number (PTAN) (see box 5 below). If your claims were billed under multiple CCNs or PTANS, you must complete separate spreadsheets identifying the SCF request claims billed per CCN or PTAN. The second tab at the bottom of this document contains the Spreadsheet Key.</td>
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</tr>
<tr>
<td>1</td>
<td>Provider or Supplier Name:</td>
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<td></td>
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<tr>
<td>2</td>
<td>Type of Entity:</td>
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<td>National Provider Identifier (NPI):</td>
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<tr>
<td>4</td>
<td><strong>CCN or PTAN</strong> <em>(One CCN or PTAN per spreadsheet, only)</em>:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>QIC Appeal Number</td>
<td>ALJ Appeal Number (if known)</td>
<td>Truncated HICN (last two numbers and the alphanumeric suffix, only; one HICN per line)</td>
<td># of Line Items Denied</td>
<td>Payer Claim Control Number</td>
<td>Billed Amount Denied</td>
<td>Claim Adjustment Reason Code (CARC)</td>
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<td>6</td>
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</table>

Settlement Conference Facilitation

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

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

- Pilot criteria on OMHA website:
  www.hhs.gov/omha/statistical_sampling_initiative.html

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

This spreadsheet includes the information required for appealed claims for which an appellant is requesting statistical sampling. Electronic submission via CD of this Claim Information Spreadsheet (or other list with the same information that is compatible with Microsoft Excel) is mandatory.

<table>
<thead>
<tr>
<th>NPI</th>
<th>QIC Number</th>
<th>ALJ Number, if known</th>
<th>Assigned ALJ, if known</th>
<th>Request for Hearing</th>
<th>Overpayment RAC Claim? [y/n]</th>
<th>Overpayment non-RAC Claim? [y/n]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
OMHA Statistical Sampling

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

- Beginning 6 month evaluation for SCF and Stat Sampling pilots
  - If any changes, expect them in January

- Continuing to explore other potential initiatives
OMHA Initiatives

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

www.hhs.gov/omha
Settlement Conference Facilitation—
OMHA.SCFS@hhs.gov

OMHA Statistical Sampling —
OMHA.stat.sampling@hhs.gov
Provider Relations Coordinator

Date of Delivery for DME

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

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

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

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

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

• Contractors acknowledge common practice to auto-fill this section
Proof of Delivery - Solution

- CMS Issues Clarification to Contractors

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

  - August 8th – DME MACs issued a joint Educational Article on Requirements
Published Educational Article – Requirements for Signature Date

- Autofilling the date of delivery on delivery documentation or Proof of Delivery is a common business practice for many DMEPOS suppliers. Upon delivery, the Medicare beneficiary or designee is required to review the POD and must provide his or her signature.

- Based on instructions, the POD delivery date element is not required to be personally filled in by the beneficiary/designee. The date of delivery maybe entered by the beneficiary, designee or the supplier. The date entered must be the actual date of service.
Increasing Access to Lower Level Appeals Adjudicators

Arrah Tabe-Bedward
Director
Medicare Enrollment and Appeals Group
Feedback from the February Appellants Forum

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

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

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

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

• Considering multiple implementation vehicles
• Will depend on the vehicle that we use
• Expect to have a decision within the next few months
Departmental Appeals Board Update
MEDICARE APPEALS COUNCIL

Judge Constance B. Tobias
Chair, HHS Departmental Appeals Board
Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD (DAB)

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

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

The Medicare Appeals Council (Council) is comprised of:

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

The Council provides the final administrative review for:

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

The Council is supported by the Medicare Operations Division (MOD) attorneys and support staff.
ALJ Decisions can be appealed by:
- Provider/Supplier
- Beneficiary
- Medicaid State Agency
- CMS own motion review

Council performs *de novo* review & can take any of the following actions:
- Adopt
- Reverse
- Modify
- Dismiss
- Remand

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

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

Number of Appeals Pending at the Council at the End of the Fiscal Year

- 2010
- 2011
- 2012
- 2013
- 2014
Appeals Received by the Council

Number of Appeals Received by the Council Per Fiscal Year
Increase in the DAB Caseload

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

<table>
<thead>
<tr>
<th>Year</th>
<th>RAC (%)</th>
<th>Other (%)</th>
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<tbody>
<tr>
<td>FY 2011</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>FY 2012</td>
<td>20%</td>
<td>80%</td>
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<tr>
<td>FY 2013</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>33%</td>
<td>67%</td>
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</table>
Beneficiary-Focus

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

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

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

• If the Council has not issued a decision within 90 days from the date it received an appellant’s request for review, the appellant may file a request for escalation to federal court in writing to the Council.

• After receiving a request for escalation, within 5 calendar days, the Council must:
  • Issue a decision;
  • Issue a dismissal;
  • Remand the case to the ALJ; OR
  • Send notice to the appellant acknowledging receipt of the request to escalate and confirming that it is unable to issue a decision.

42 C.F.R. § 405.1132
Managing the Increasing Caseload: Council’s Actions

• Electronic records
• Appeal consolidation
Electronic Records

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

- Appeals filed by a single appellant with identical issues of law and no significant factual dispute are being consolidated
- The Council issues one decision in consolidated appeals which allows the affected appeals to be processed more quickly
PRACTICE TIP:
Follow the instructions in the Council’s Acknowledgement Letter

When filing a request for review:

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