



**MLN Connects®**

**National Provider Call Transcript**



Official Information Health Care Professionals Can Trust

**Centers for Medicare & Medicaid Services  
Improvements to the Medicare Claims Appeal Process  
and Statistical Sampling Call  
MLN Connects National Provider Call  
Moderator: Charlie Eleftheriou  
June 29, 2017  
1:00 pm ET**

**Contents**

Announcements and Introduction ..... 2

Presentation ..... 2

    Medicare Appeals Final Rule: General Provisions..... 4

    Requests for ALJ Hearing ..... 8

    Dismissals ..... 14

    Remands ..... 15

    CMS and CMS Contractors ..... 17

    Hearings and OTR Decisions ..... 19

    New Evidence..... 21

    Miscellaneous Provisions ..... 23

    Statistical Sampling Initiative ..... 27

Question and Answer Session ..... 32

Additional Information ..... 47

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. This transcript may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

**Operator:** At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Charlie Eleftheriou. Please go ahead.

## **Announcements and Introduction**

Charlie Eleftheriou: Hi. This is Charlie Eleftheriou from the Provider Communications Group at CMS in Baltimore, and I'm your moderator today. Welcome to this MLN Connects National Provider Call on Improvements to Medicare Claims Appeal Process and Statistical Sampling.

MLN Connects Calls are part of the Medicare Learning Network®. During this call, you'll learn about changes intended to streamline the administrative appeal processes, reduce the backlog of pending appeals, and increase consistency in decisionmaking across appeal levels.

Before we get started, I have a couple of announcements.

If you have not already done so, you may view or download the presentation for today's call from the following web address – [www.cms.gov/npc](http://www.cms.gov/npc) as in National Provider Call. Again, that's cms.gov/npc. At the left side of the page, select National Provider Calls and Events and then select the date of today's call from the list on that webpage.

Also, we're recording this call. The audio recording and the transcript will be posted to the MLN Connects Call website. We're happy to welcome our colleagues in the Office of Medicare Hearings and Appeals who will be presenting to you today.

To get started, I'll turn the call over now to Jason Green.

## **Presentation**

Jason Green: All right. Thank you. And welcome to everyone joining us today and thank you for your patience in getting started. My name is Jason Green, and I am the Chief Advisor at the Office of Medicare Hearings and Appeals or, as we refer to it, O-M-H-A, or

OMHA, which is part of the Office of the Secretary of the Department of Health and Human Services.

Before we get started, I want to orient everyone a bit and provide some context for this presentation. OMHA is generally the third of four levels of administrative appeal for claims for items and services furnished to Medicare beneficiaries as well as beneficiary entitlement and certain premium issues. We're commonly referred to as the ALJ hearing level.

But keep in mind there is another cadre of ALJs within HHS that work on provider/supplier enrollments issues, LCD challenges, etc. And those sit with the HHS Departmental Appeals Board. So, we're focused on claims for items and services furnished to Medicare beneficiaries here at OMHA.

Now the first two levels of the Part A and Part B Fee-for-Service claim appeals process are administered by CMS through its contractors, generally the Medicare Administrative Contractors, or MACs, which make initial determinations and conduct the first level of appeal, the redetermination, and the Qualified Independent Contractors, or QICs, which conduct the reconsiderations as the second level of appeal.

And Maria Ramirez from the CMS Medicare Enrollment and Appeals Group has been kind enough to join us today. So, if there are any spontaneous questions about them, she will maybe be able to answer those.

And then there is the fourth level of administrative appeal after the ALJ hearing. And that's conducted by the Medicare Appeals Council at the HHS Departmental Appeals Board, which, like OMHA, is a component within the Office of the Secretary of Health and Human Services.

So today's presentation will focus primarily on the OMHA level of appeal. For the first part of today's presentation, I'll be joined by Amanda Axeen, the Director of Program Policy here at OMHA, and we'll take you through some highlights of a final rule that was published in January and took effect in March.

Then Anne Lloyd, our Director of Field Operations and Special Initiatives at OMHA, will discuss an option available at OMHA to use statistical sampling as an efficient way to handle appeals if you have more than 250 eligible claims pending at our level.

And as we go through these slides that have been made available, we'll try and refer to the slide deck, recognizing that this is an audio and you'll need some way to keep track of what we're talking about.

So, moving on to slide 2, we have our standard disclaimer that this presentation is for the purposes of presentation only. We discuss and summarize rules, but you should always refer to the published rules and other written guidance for official statements of policy and explanation.

Moving on to slide 3, you'll see our agenda for today's presentation. The Medicare Appeals Final Rule, as we're referring to it, was published on January 17 of 2017 and is available online at the *Federal Register* website. The rule contains many detailed provisions and discussions of the rule changes, and we encourage those of you who engage in the appeals process to read it in full.

But for today, our focus is a bit more higher level to give you an overview of the changes with an emphasis on those that impact the appellant community.

The first portion of today's presentation will focus on the seven highlighted topics and then a few miscellaneous provisions of the new rule that we felt warranted mention.

And then our presentation is also going to focus on the 405 rules, which is 42 CFR Part 405, the appeal rules that apply to Part A and B Fee-for-Service claim appeals. But, we have provided some citations to Part 423 rules, which apply to Part D appeals for those of you who engage in those appeals.

### **Medicare Appeals Final Rule: General Provisions**

Moving on to slide 4. The first area of our – of the changes we're going to discuss are to general provisions of the rule.

On slide 5, you'll see a summary of new Section 401.109, which is a new provision that gives the chair of the HHS Departmental Appeals Board the authority to designate a decision issued by the Medicare Appeals Council as precedential. Under new

Section 401.109, a decision that is designated as precedential means that the decision is binding on all adjudicators at all levels of review, including CMS contractors, OMHA adjudicators, and the Council itself.

As we explained in the final rule, precedential decisions will be made available on the Council's website, and a notice of a precedential decision would also be published in the *Federal Register*, not the decision itself but, rather, notice that the decision has been designated.

In determining which decisions are designated as precedential, the rule provides that the Departmental Appeals Board chair considers decisions that address, resolve, or clarify recurring legal issues, rules, or policies or that may have broad application or impact or involve issues of public interest.

Moving on to slide 6. In most decisions that are designated as precedential, we expect the precedent to be applied would be the Council's legal analysis and interpretation of a Medicare law or policy. And that interpretation would then apply to all future appeal determinations where that law or policy was in effect on the date of service or date of initial determination.

However, the rule also contemplates that there may be limited circumstances in which factual findings may be designated as precedential in future appeals if there is evidence that the underlying factual circumstances are unchanged.

For example, if the Council finds that the – that evidence establishes that a Medicare beneficiary was unlawfully present in the United States during a certain time period, that finding could be designated as precedential in future appeals.

Decisions that are designated as precedential can be appealed just like any other case to Federal District Court, but there is no separate means to appeal the precedential designation.

We do note that if CMS disagrees with the Council's legal analysis and interpretation of Medicare law or policy, CMS can revise the law or policy, in which case the precedential decision would not apply to claims or disputes to which the revised revision, rule, or

policy applies. So that is, once CMS makes a change to the law or policy, the precedential decision wouldn't apply because it only applies to the prior version.

On to slide 7. The next general provision concerns attorney adjudicators, which is a new type of adjudicator here at OMHA. As defined in revised Section 405.902, an attorney adjudicator is a licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance and authorized to take the actions provided for in this subpart, which is Part 405 Subpart I, on requests for an ALJ hearing and requests for reviews of QIC dismissals.

On slide 8 and on slide 9, we have a table that compares the ALJ and attorney adjudicator authority. And OMHA is still in the process of implementing the program. But these tables list some of the actions an attorney adjudicator is authorized to take compared to ALJs.

The first difference you'll notice, which is probably the most important one for the – for you on the line, is that attorney adjudicators are not authorized to conduct a hearing, which also means they cannot issue a decision in any case where a hearing is necessary to issue that decision.

However, attorney adjudicators can issue decisions when a hearing is not required, including cases where the record supports a fully favorable decision, cases where the parties who would receive a notice of hearing have all waived their right to that hearing, and decisions on requests for review of a dismissal.

Attorney adjudicators are also authorized to issue remands and dismiss a request for review of a dismissal. And they can also dismiss a request for hearing if the appellant is withdrawing that request. And we'll talk a little more about that.

Focusing on slide 9 for a moment. Attorney adjudicators can request information from CMS or a CMS contractor, make good cause determinations on the submission of new evidence, and determine that the amount in controversy requirement was met for a request for hearing. And we highlight that to note that they can make a finding that it was met.

However, they cannot make a finding that it was not met because they cannot dismiss a request for ALJ hearing with the exception of when the appellant is withdrawing it. So if there's a question of whether the amount in controversy was met for a request for hearing, in that instance, any case that was assigned to an attorney adjudicator would be transferred to an ALJ for a decision on that.

Moving on to slide 10, application of Part 405 to other parts. We are addressing how the rules for Part A and Part B claim and entitlement appeals in 42 CFR Part 405 apply to Part C Medicare Advantage appeals in Part 422 and QIO reconsideration appeals in Part 478. All these part references are to 42 CFR for those of you less familiar with our nomenclature. The Part 405 rules apply to the Fee-for-Service program and provide the basis for most of our appeals processes.

Currently, there's a provision in the Part C rules that says the Part 405 rules apply to the extent appropriate. There's a similar provision in the QIO rules in Part 478. And this has led to some confusion because of the generic reference back to Part 405 when a Part 405 provision is based on a specific section in the act that is not also in another provision of the act.

So Section 1869 of the Social Security Act lays out the statutory requirements for Fee-for-Service appeals, but other sections of the act lay out the requirements for Part C and QIO appeals. So when a Part 405 provision is specific to 1869, we have questions about whether that would apply to the other appeal types.

Moving on to question— sorry – slide 11. To address this confusion, the final rule specifies three principal areas where the Part 405 rules derived from statutory requirements are not applicable to appeals brought under the Part C rules, Part 422, or the QIO rules, Part 478.

Those three areas are adjudication timeframes for any level of appeal. This is not only because Sections 1155, 1852, and 1876 of the act don't contain these timeframes – those sections lay out the different appeals processes for other appeals – but also because their implementing regulations establish timeframes for lower-level appeals that are different from – I'm sorry – 1869 appeals.

Another area are provisions that allow for escalation of an appeal when an adjudication timeframe is not met. So under the A B rules, you can escalate an appeal if a QIC did not decide its case in time or we didn't decide our case in time. You could escalate to the next level. That escalation is not available in other areas.

The third area are any rules that require a good cause determination for the introduction of new evidence by a provider or supplier or beneficiary represented by a provider or supplier. This rule comes from a specific section, 1869(b)(3), of the act and is implemented in the 405 rules. However, it's not appropriate to apply that rule to the other sections – other parts.

The last general provision to discuss today deals with references to the Medicare Appeals Council. Previously, the regulations referred to the Medicare Appeals Council interchangeably as the Departmental Appeals Board, the Medicare Appeals Council, the DAB for shorthand, and as well as the MAC for shorthand. The MAC was particularly confusing given the Medicare Administrative Contractors are also referred to as the MAC.

So we endeavored to just make the reference to Council. So, that is your new shorthand for the Medical Appeals Council in the rules. And we made changes to all the rules so they are aligned. So now it is the Council, not the MAC. So no more confusion with the Administrative Contractors.

And now we'll move on to requests for ALJ hearing. And Amanda will take us through that.

### **Requests for ALJ Hearing**

Amanda Axeen: Yes. Hello. I'm going to cover some topics that relate to filing a valid request for hearing with OMHA because you want to get off on the right foot and avoid what can become a common procedural hurdle.

In addition to the rule changes I'm about to cover, I also wanted to take this opportunity to highlight that earlier this year, OMHA adopted a new Unified Request for ALJ Hearing or Review of Dismissal Form, which is called the OMHA-100. The OMHA-100 is user-friendly and helps walk you through all of the information required for a valid request for ALJ hearing or review of a dismissal.

The OMHA-100 form can be used by you, an appellant, to request an ALJ hearing or review of a dismissal for an appeal arising under any of the Medicare parts. Previously, there was no official form for Part D requests.

And this form also includes additional case processing information for all types of appeals. So, it's not required. But please consider using the OMHA-100 form when filing a new request for ALJ hearing or review of a dismissal. If you choose not to, do ensure that your request includes all of the required elements in the regulation in 405.1014(a) and, in particular, make sure to include the full beneficiary health insurance claim number on the request. And, of course, that form is available on our website.

So the first topic I'm going to turn to – moving on to slide 14 – is the amount in controversy. This phrase is really a legal term of art, and it refers to the amount of money at issue in an appeal. This is sometimes referred to as a threshold amount because you must have a minimum amount in controversy to bring your appeal before OMHA.

As you know, that amount is set by – as you may know, that amount is set by statute and it adjusts annually. It's published in the *Federal Register*. And for appeals filed in calendar year 2017 – so, the current amount is \$160. But the statute does not specify how the amount in controversy should be calculated. So that calculation has been established by regulation.

Moving on to slide 15. The old rule at – so all of the amount in controversy information is at 405.1006. It used – it stated that the amount in controversy is calculated as the actual amount charged an individual for the items or services in question reduced by any Medicare payments already made or awarded for the items or services and further reduced by any deductible and coinsurance amount applicable in that particular case.

There was one exception to this general methodology for when payment is made pursuant to 1879 of the act or 42 CFR 411.40. So that's when there's a waiver of liability or limitation on liability.

And this formula worked in most cases. But there were a few scenarios where it didn't work. And so, to address these scenarios, the final rule added four new exceptions,

which explain how to calculate the amount in controversy in an appeal when there is – when the appeal concerns item or service termination, overpayment, coinsurance and deductible challenges, fee schedule or contractor price challenges.

For all other scenarios, the final rule largely left the existing methodology intact, but there were some minor revisions made for clarity.

Moving on to slide 16. Aggregation essentially refers to the process of combining several smaller claims to meet the amount in controversy threshold. In the past, appellants sometimes filed a request for hearing on one claim with a request to aggregate that claim with another claim in an appeal that had already been filed.

Because of the logistics of our paper-based system and the appeals backlog at OMHA, this is administratively burdensome and led to even more processing delays. Therefore, the rules regarding aggregation have been revised to resolve the existing confusion and to clarify that appellants must request aggregation at the same time they file the request or request for hearing for the claims they wish to aggregate.

The last thing I wanted to touch on about amount in controversy is that the proposal to revise the calculation methodology for items and services priced on a published Medicare fee schedule or with a published contractor price amount was not finalized. That proposal had called for Medicare allowable amounts to be used as the basis of the amount in controversy before any deductions.

But in consideration of the public comments received on the proposal, as well as the cost to the Government and appellants to implement this, the proposal was pulled back and, as we mentioned, the existing methodology and the new exceptions now apply.

This takes us to content and copy requirements for ALJ hearing requests. And I'll start with the content requirements. This is on slide 17. There is really only one added requirement for the request for hearing other than some clarifications for appeals involving statistical sampling and extrapolation that we will address in more detail at a later slide.

The new requirement is that a telephone number must now be included for the appellant, which is oftentimes the provider or supplier, the beneficiary if the beneficiary is the appealing party and is not represented, and the representative, if any.

This is already required in Part D appeals. And although not required by regulation in the other appeals, there's always been a place for telephone numbers on the standard Request for Hearing Form. So it's really not that much of a change.

The regulations now also specify that all appellants must be given an opportunity to cure an incomplete a request for hearing and that any applicable adjudication periods do not begin until they do so.

So when determining if a request is complete, any supporting materials that accompany the request for hearing must also be considered if they clearly provide the required information.

So to provide an example of this, if a request for a hearing comes in and it does not contain the QIC Medicare appeal number but a copy of the QIC reconsideration is attached that would bear that number on the first page, that is sufficient to satisfy the requirement.

And here I also wanted to highlight that the proposed rule had contained a provision that would have required appellants to disclose whether they were aware that they or the claims being appealed were the subject of an OIG investigation or other law enforcement action.

That provision was not finalized. And there was also a proposal that appellants other than beneficiaries who were not represented by a provider, supplier, or Medicaid agency would have to include the amount in controversy on their request for hearing. But that was not finalized either.

So moving on to slide 18. Some of you more frequent filers maybe aware that you are required to send a copy of the request for hearing or request for review to other parties and that this requirement has caused some confusion for appellants and adjudicators alike. So the final rule made a number of clarifications in this area.

And the next few – the next couple of slides are going to deal with that. So some of the changes have been – some of the revisions were in 405.1014, but then they're also in – there's a new section (d) as well.

So the old rule explicitly applies only to requests for hearing. But the new rule clarifies that it also applies to requests for review of a dismissal. Under the old rule, all parties had to be copied. But under the new rule, only parties who were sent a copy of the QIC's reconsideration need to be copied. And that's to provide some clarity.

In terms of what must be sent, the old rule specified only the request for hearing. But the term "request for hearing" was interpreted differently by different people. Some felt it encompassed only the request for hearing itself, while others interpreted it to also include any materials submitted with the request.

The final rule clarifies that the request for hearing and any additional materials submitted with the request for hearing that are required to complete the request must be sent to the other parties who received a copy of the QIC's reconsideration.

So thinking back to the example I had just touched on about the request for hearing that was missing the Medicare appeal number but where a copy of the reconsideration was submitted and would have that number, both the request and the reconsideration notice would need to be sent to the other parties who received a copy of the QIC's reconsideration because those two documents together form the complete request for hearing.

And then, any additional evidence that is submitted with the request for hearing – if any additional evidence is submitted, it may be sent along with a copy of the request for hearing or you as the appellant may briefly describe the evidence and offer to provide copies to the other parties at their request.

Moving on to 19 – slide 19. Previously, the rules were silent on what constituted acceptable or sufficient evidence that the required copies of the request for hearing were in fact sent. OMHA had previously published sub-regulatory guidance on this topic in its – in our case processing manual, and much of that information is now included in the regulation that's at 405.1014 (d)(2).

So you may complete the certification in Section 10 of our new Request for Hearing Form, that OMHA-100 that I mentioned, you could include a copy or a CC line on your request for review or hearing if you're doing it in more of a letter format. Appellants may also submit an affidavit or a Certificate of Service or a mailing receipt. But these forms of evidence must identify both the name and address of the recipients as well as what they were sent. So just to be clear, not all four of those options or five of those options are required. Any one would be sufficient to establish sufficient evidence that the copies were sent.

The last thing I want to discuss is what happens if there is insufficient evidence that the required copies were sent. If the request was filed by an appellant other than an unrepresented beneficiary, the appellant would be given an opportunity to cure, which – during which time the adjudication deadline is tolled.

That means that you would have time to fix your request for hearing and make sure that the copies were sent and tell us that. If the appellant does not provide evidence that copies were sent within the required timeframe, the request will be dismissed. The regulation doesn't specify the timeframe, but our sub-regulatory guidance, the Case Processing Manual, currently calls for a 60-day timeframe with interim cure letters.

And then I just wanted to highlight that for appeals that are filed by unrepresented beneficiaries, the rule does not call for the same process and specifically exempts appeals from potential dismissal for failure to send the required copies.

In the preamble to the final rule, we discussed that if it is not apparent that the required copies have been sent, it has been the historic practice of both OMHA and the Council to send notice of the request to other parties on behalf of an unrepresented beneficiary. And we believe that that should continue to be the practice after the final rule.

Moving on to slide 20, which is the last topic in this section, it's Appointed Representatives.

As you are probably aware, the Medicare Claims Processing guidance – Manual and guidance and the official Form CMS-1696, which is the Appointment of Representative Form, both require that a valid instrument for designating an appointed representative include the beneficiary's HIC number if the beneficiary is the party appointing the

representative or the National Provider Identifier, or NPI, if the provider or supplier is the party appointing one.

So the prior regulation had stated that the beneficiary's HIC number was required without regard to which party was appointing the representative. So the regulation was changed in 2015 to clarify when a HIC number is required. But the requirement to include the NPI was not added at that time.

So now the changes finalized with this rule – it mirrors the requirements in the Medicare Claims Processing Manual and also on the form, Form 1696.

So moving on to slide 21. Before the final rule, the prior rule – the prior regulations provided a process for curing defective appointments of representatives, but they did not state what effect this cure process had on adjudication timeframes. To address this, the final rule added a new section that states that any applicable adjudication timeframe is tolled until the defect is cured or the party notifies the adjudicator that he or she will proceed without a representative.

There are also some new provisions regarding delegation and revocation of appointments of representatives. And I've provided those paragraphs here so you can review them. But, in the interest of time, I'm not going to get into them too far.

So I'll turn it back over to Jason.

## **Dismissals**

Jason Green: All right. Thank you.

So beginning on slide 22 and moving quickly on to slide 23, we want to touch briefly on dismissals. The section that covers dismissals, 405.1052, has a few updates. But the most important one for many of you is that we revised 1052, specifically adding subsection (e) and 405.1054 to provide that an attorney adjudicator or ALJ may vacate a dismissal of a request for hearing or a request for review.

Previously, appellants had to appeal any dismissal from the OMHA level, which was time-consuming and inefficient for them and the Council.

So now, if an appellant believes an appeal was dismissed in error or an ALJ or attorney adjudicator determines his or her dismissal was an error, an appellant can bring that to the adjudicator's attention or the adjudicator can vacate a dismissal on his or her own motion, and then that will be vacated and the request for hearing will resume or request for review.

One important caveat is that requesting that a dismissal be vacated, if you as the appellant are submitting that request to the adjudicator, does not toll or extend your time period for filing a request for the Council to review that dismissal.

And the determination of whether or not to vacate a dismissal is left to the OMHA adjudicator's discretion. So that's one thing you'll want to keep in mind when deciding whether to request that the OMHA adjudicator vacate his or her dismissal or you submit an appeal to the Council to review that.

## Remands

Moving on to slide 24, our next topic is Remands.

And slide 25 shows you some distinctions between the old rules and the new rules. These changes were a bit more significant than the dismissal changes. Previously, 405.1034 was our remand rule.

And it provided that if a record was missing information that was essential to resolving of issues on appeal and that information could be provided only by CMS or its contractors, then the ALJ could either remand the case to the QIC or retain jurisdiction and request the missing information from the QIC.

Under the new rules, the process for requesting information is retained at 405.1034. And the remands and the effect of the remands are covered in new Section 1056 and 1058. The circumstances under which a remand may be – or a remand may be issued versus when jurisdiction should be retained are more explicitly spelled out in the new rule.

On slide 26, we look at the requests for information. You'll see that the conditions under which a request for information may be issued are basically the same as the old rule. But there is no longer an option to remand for missing information here.

This is because under the old rules, when an ALJ remanded for -- a case for missing information, if the QIC was able to furnish it, the case would be returned to OMHA with the missing information and generally without a new reconsideration. So, practically, the result was the same as retaining jurisdiction and requesting the information.

But it was administratively more complex for us, CMS contractors, and it was confusing for appellants and caused delays.

Another change is that the rule now specifies that the QIC has 15 calendar days from receipt of a request for information to furnish it. And there is a tolling event of the adjudication timeframe if one applies to the appeal until the QIC responds to the request or 20 calendar days have elapsed, whichever occurs first. So we have built in there some mailing time or transition time for information in addition to the 15 calendar days response period.

Now moving on to the new provisions for remands on slide 27. What if the QIC, for instance, doesn't respond to a request for information? If the request was for an official copy of a redetermination or reconsideration or if the QIC was unable to furnish the case file, Section 1056 provides that the case may be remanded to the QIC to either reconstruct the record or, if it's unable to do so, initiate a new reconsideration.

And once again, if a case is returned to OMHA with the documentation, the adjudication period is extended but the case would pick up where it left off.

Section 405.1056 also provides that a remand may be issued when the QIC issues a substantive reconsideration but there is no evidence that a redetermination was ever conducted or there is evidence that the redetermination request was dismissed.

The reason for that is that the Medicare Administrative Contractor, if it dismissed a request for redetermination, the QIC should have reviewed the dismissal instead of issuing a substantive reconsideration on coverage. And if there was no redetermination, there was no authority to issue a reconsideration.

The last situation under which a remand is permitted other than a remand of a request for review of a dismissal, which is unchanged, is when the appellant and CMS or CMS contractor jointly requests that a case be remanded to the QIC.

The request to remand must include the reasons why the remand will likely resolve the matter in dispute. For example, the QIC is requesting a remand in order to pay a claim that it has now determined is payable. This check is in the rules to ensure that if we do remand, the case will be resolved back at the lower level.

Moving on to slide 28. An added feature of new 405.1056 is the ability for a party, CMS, or CMS contractor, to request that the OMHA Chief Administrative Law Judge or her designee review a remand that the requestor believes was not authorized under 405.1056.

There was previously no way for an appellant or CMS or its contractors to address a remand that they did not agree with, which led to confusion when the disagreement was on whether the remand was authorized under the rules.

The new rule allows for a request for a review of that remand to be filed within 30 days of receiving the notice of remand. And if the Chief Administrative Law Judge or designee determines that the remand was not authorized, the remand order is vacated and the case is returned to OMHA and resumed.

Please note that the review of a remand is not available for remands where the request for a review of a dismissal was appealed because, as we explained in the final rule, the remand in these circumstances is more akin to a determination rather than a purely procedural mechanism.

I'll turn it over to Amanda to cover CMS and CMS contractor rule changes.

### **CMS and CMS Contractors**

Amanda Axeen: So that brings us to slide 29 and, really 30. So this section is laid out in a table because the changes to the sections involving CMS and CMS contractor participation in hearings are significant, and it may be a little easier just to see it this way on a chart.

As a preliminary note, I do want to emphasize that just as in the prior rule, the new rule allows CMS and CMS contractors to elect to be a party or participant in Part A and Part B appeals. But they may only request, not an election, in a Part D appeal, and they may only request to be a participant, not a party. So that's why you'll see the term "election" and – or "elections/requests" in this table.

However, because of space constraints, I've only again really included Part A and B rules here. So, I just wanted to flag for folks that are working in the Part D and Part D expedited appeal areas that there are some differences there.

The first significant change for the Part A and B appeals is that there are now two opportunities for an election or request to be filed. The first opportunity is within 30 days after notification that a request for hearing was filed. But the caveat is that elections and requests filed at this stage may only be for non-party participant status.

The second opportunity occurs only if a hearing is scheduled and allows for an election or request for participant status or a party status election to be filed within 10 calendar days after receipt of the notice of hearing.

The second change, which is actually a change to the regulation at 405.1020(c), clarifies that in addition to all the usual recipients of a notice of hearing, notice must also be sent to CMS or a CMS contractor that elected or requested to participate in the proceedings during that first opportunity I just discussed and CMS or CMS contractor whose attendance the ALJ believes would be beneficial.

So moving on to slide 31. The next change – and this is another significant one – is that there is now a limit on the number of entities – and we use that term "entities" to refer to CMS, CMS contractors, and a Part D plan sponsor – that may be made a party and that may attend an oral hearing.

This change was made in response to feedback from adjudicators and appellants indicating that when multiple entities participated in the same hearing, the hearings not only took longer and were more challenging to coordinate, but they also could become more adversarial.

Under the new rule, preference is given first to parties. And if multiple entities elect to be a party, only the first to file the party election is allowed to attend the oral hearing with the rest being made non-party participants. So if no entity elects to be a party, the first entity to respond –so, if no entity elects to be a party, the first entity to respond will – is the – to the notice of hearing will be the one that is made the party.

And ALJ also has the discretion to allow additional entities to attend the oral hearing. And if an entity is excluded from participating, an entity participating as a party may still call the precluded witness – the precluded entity as a witness despite the usual prohibition on CMS and CMS contractor participants being called as witnesses. However, doing so would also open up the precluded entity to cross examination by the other parties.

The last thing worth noting here is that the rule at 405.1038(a) now explicitly prohibits an OMHA adjudicator from issuing a fully favorable decision without the opportunity for a hearing if CMS or a CMS contractor has elected to be a party in the hearing.

We expected this to be a rare occurrence anyway since party elections may only be made after the issuance of a notice of hearing and normally, you know, an on-the-record, fully favorable decision would have been issued prior to the hearing being scheduled.

### **Hearings and OTR Decisions**

Moving along to the next slide, 32. The next couple of topics have to do with hearing and on-the-record decision issues.

The final rule – moving to slide 33, the final rule added one new scenario under which a decision may be issued on the record and what is called a stipulated decision. This new rule allows for OMHA adjudicators to more efficiently issue decisions on the record when the issues that led to the original claim or coverage denial are no longer disputed by CMS.

So in order for an OMHA adjudicator – so, either the ALJ or attorney adjudicator – to issue a stipulate decision on this basis, CMS or a CMS contractor must either submit a statement in writing or make an oral statement at the hearing indicating that the item or service at issue should be covered or payment may be made.

In addition, if the amount of payment is an issue, CMS must agree to the amount of payment the parties believe should be made. Where these conditions have been met, an OMHA adjudicator may issue a favorable decision on the record without making findings of fact, conclusions of law, or further explaining the reasons for the decision.

Moving on to hearings and slide 34. As many of you know, the regulations require us to send a notice of hearing when the hearing is scheduled and, then, you as appellant, usually the provider or supplier, has to respond.

The rule now requires that parties specify in their responses to the notice of hearing the witnesses who will be providing testimony at the hearing and if the party or representative is an entity or organization, including CMS or a CMS contractor, specify who from the entity or organization plans to attend and in what capacity.

So OMHA recently revised the Response to Notice of Hearing Form, which had been HHS-729, and it's now been re-designated as Form OMHA-102. And the new form includes a space to provide this information. So, it's right there for you.

Moving on to the next slide, slide 35. If a party objects to the time or place of a hearing, the current – the prior rules required that the objection be in writing, except for expedited Part D requests. The new rules refer back to and allow for an oral request in any case where an emergency circumstance arises the day prior to or the day of the scheduled hearing. The rules also add two new examples to the list of examples for when there may be good cause to change the time or place of the hearing.

These two new examples are when the party has a prior commitment that cannot be changed without significant expense – think scheduled travel – maybe a cruise? -- and when the party or representative asserts that he or she did not receive the notice of hearing and is unable to appear at the scheduled time and place.

Finally, if the time and/or place of the hearing is changed, the regulation at 405.1020(j) requires that an amended notice of hearing be sent to all parties who were sent a copy of the notice of hearing as well as CMS and any CMS contractors that elected party or participant status. This was generally OMHA's practice, but now it is a requirement in the regulation.

So this next topic on – starting with slide 36 starts with a graphic. The graph shows the percentage of hearings that were conducted by telephone every fiscal year since 2006. But for that one blip in 2011, there's a very apparent trend toward more and more hearings being conducted by telephone. It's up from roughly 75 percent in 2006 to 99.5 percent so far through March of 2017.

Moving to slide 37. Hopefully, that graph puts this next slide into context a little bit. Given that the overwhelming preference of appellants is for hearings by telephone and those are somewhat less costly for us to administer and easier to coordinate, the final rule changed the default mode for appearances by appellants other than unrepresented beneficiaries from VTC or video teleconferencing to telephone. For unrepresented beneficiaries, VTC remains the default. But the ALJ may offer to conduct the hearing by telephone instead. This is the same as the prior way of doing it.

If a party other than an unrepresented beneficiary requests a hearing by video teleconference or VTC, the ALJ may find good cause for one if VTC is necessary to examine the facts or issues involved in the appeal.

If VTC and telephone technology are not available or special or extraordinary circumstances exist, the ALJ, with concurrence from the Chief of ALJ or her designee, may also find good cause for an in-person appearance by an unrepresented beneficiary or any other appellant.

So the takeaway from this slide is that appellants other than unrepresented beneficiaries will now need to show good cause for appearance by VTC.

And with that, I'm going to turn it back over to Jason for new evidence.

### **New Evidence**

Jason Green: Thank you. So on slide 39, we'll begin this section.

I briefly mentioned new evidence when I discussed the application of Part 405 to the other appeals Parts C and D and QIOs. But there are also more substantive changes to the rules that apply to new evidence when those rules are applicable in Part 405 appeals.

Prior Section 405.1018 required that any new evidence submitted for the first time at the OMHA level be accompanied by a statement explaining why it was not previously submitted to the QIC or prior decisionmaker.

This final rule revised the requirement, which is now in Paragraph (d)(2), to explain that if the statement is not provided with the evidence, the evidence will not be considered. So if you fail to explain why you're submitting new evidence at the OMHA level and this rule applies to you, if you – you will not get that evidence considered if you don't provide the explanation.

In addition, prior Section 405.1018(d) stated that the requirements of 1018 did not apply to oral testimony given at a hearing or to evidence submitted by an unrepresented beneficiary.

However, this statement was incomplete. The statutory provision that limits new evidence limited the evidence submitted by a provider or supplier, which caused confusion under our prior rules when a state or CMS contractor submitted new evidence as well as when other non-provider or supplier parties submitted evidence.

To address this, the final rule added Paragraph (d)(2) to clarify that a showing of good cause is not required for evidence submitted by the unrepresented beneficiaries or beneficiaries who are represented by someone other than a provider or supplier, CMS or any of its contractors when they have elected party status and can submit evidence, a Medicaid state agency, or an applicable plan in a Medicare secondary payer appeal where the overpayment recovery action is taken against the plan.

Moving on to slide 40. The other regulatory provision that implements the statutory limit on new evidence is 405.1028. Previously, that section included only one example of what could constitute good cause for the introduction of new evidence.

And that is where the new evidence is material to an issue addressed in the QIC's reconsideration, and that issue was not identified as material prior to the QIC's reconsideration. So, basically, the QIC denied on the new issue. You could submit new evidence at our level to address that issue.

The final rule provides four new examples in addition to that example on when good cause may be found. So we want to highlight those here.

When the evidence is material to an issue identified after the QIC's decision – so, if the ALJ identifies a new issue, you will be able to submit new evidence on that because there'd be good cause because it's a new issue that you didn't previously know about.

When the material was unable to be obtained prior to the QIC's decision, despite evidence that reasonable attempts were made – again, you're making some attempt here to obtain the evidence and you're documenting that.

So you're able to show through evidence that you're making such efforts. When there is evidence that the new evidence was previously submitted to the QIC or another contractor but, for some reason, it is not found in the administrative record. This is to address questions we've heard from appellants about what they assert is missing evidence.

So if there's documentation that you sent it to QIC or another contractor but it's not showing up in the record, you can show that evidence to the judge when submitting additional evidence at our level.

And the last example is similar to the second but does not require evidence of reasonable attempt. This example is meant as a catch-all to provide the ALJ or attorney adjudicator with discretion to find good cause in situations that don't exactly match any of the more specific examples in the new rule.

So, with that, I will turn it back over to Amanda for the miscellaneous provisions.

### **Miscellaneous Provisions**

Amanda Axen: Yes. So these are some topics in the final rule that are important to mention here today but don't really – they're not really related necessarily. That's why they're in the Miscellaneous section.

So the first slide, slide 42, touches on limiting testimony and argument. This is really two different topics. So there's a new section that was added to allow ALJ testimony – to

allow an ALJ to limit testimony or argument that is irrelevant to the issue, repetitive, or relates to an issue that is sufficiently developed or on which the ALJ has already ruled.

So we stated in the final rule that we expected this authority would be used sparingly and only in the situations described. The rule also permits the ALJ to allow additional written statements and affidavits on the issues for which testimony or arguments were limited. But the ALJ is not required to do so.

The other new provision allows an ALJ to excuse from the hearing a party or representative who is uncooperative, disruptive, or abusive. However, the ALJ must first give the party or representative a warning that if the behavior continues, they will be excused from the hearing.

And in situations where the behavior continues and the ALJ excuses the party or representative, the ALJ is required to provide an opportunity for the excused individuals to submit written statements and affidavits and the party may request a copy of the hearing recording in order to respond to statements made by other parties, participants, or witnesses. So we really hope this won't be an issue for anyone on the phone, but just in case.

Moving on to slide 43, the next topic is adjudication timeframe. And there are a few provisions in the final rule that are noteworthy in this area. So the first – the final rule revised the language in Section 405.1016(a) and (c) that had previously stated that an ALJ must issue a decision, dismissal, or remand to the QIC within 90 days for appeals of QIC reconsideration or 180 days for appeals that are escalated from the QIC to OMHA. The revised language simply states that an ALJ or attorney adjudicator issues the decision, dismissal, or remand to the QIC within those same timeframes.

So in the final rule, we explained that different courts have come to different conclusions about the mandatory nature of the Section 1869 adjudication timeframe. But it is OMHA's and the Department's position that the statute prescribes the remedy of escalation for failure to meet the timeframe.

Because escalation is the appropriate remedy, the word "must," which we stated in the final rule should be reserved for absolute requirements, was removed to more appropriate set expectations.

However, the removal of “must” in no way diminishes the general expectation that a decision, dismissal, or remand will issue within that applicable timeframe. That’s because the statute, that Section 1869 timeframe, is still in place.

The next provision is a new section which states that for cases that are remanded from the Council and were previously subject to an adjudication timeframe, that same timeframe will apply to the remanded appeal. The time will begin on the date that OMHA received the Council’s remand. The prior rules had been silent on this issue. So it’s to ensure that the cases that come back from the Council keep moving.

Next, the prior Section 405.1104 dealt with escalations. It’s been removed and replaced with a new section, which is 405.1016(f).

The new rule simplifies the old two-step process for requesting escalations to the Council and now requires appellants to file a single escalation request with OMHA and send a copy of that escalation request to the other parties who were sent a copy of the QIC reconsideration.

If an attorney – if an ALJ or attorney adjudicator is not able to issue a decision, dismissal, or remand within 5 days from receipt of the request for escalation or 5 days from the end of the applicable adjudication period, OMHA will send a notice to the appellant and forward the case file to the Council.

Finally, the new rules do create some new tolling events like the one I discussed earlier that was associated with invalid appointment of representatives.

Moving on to slide 44. The next two slides deal with some special rules and clarifications for cases involving overpayments determined through statistical sampling and extrapolation.

As you may recall from an earlier slide, the cases involving overpayments in general – there is an exception to the amount in controversy calculation that states that that amount is the amount of the overpayment specified in the demand letter.

That new regulation – the new exception in the regulation also explains that for appeals that involve an estimated overpayment determined through the use of statistical

sampling and extrapolation, the amount in controversy is the total amount of the estimated overpayment determined through extrapolation. So, that's – it's really just what was going on probably, but it just clarifies it.

The next few clarifications deal with the content requirements in – to have a valid request for hearing or review of a dismissal. Those are in the 405.1014. When an appellant disagrees with how a statistical sample and/or extrapolation was conducted, there are three requirements. And these are laid out in 405.1014(a)(3).

First, appellants must include the information required for each sample claim being appealed. So, for example, 405.1014(a)(1)(vi) requires the appellant to state the reason he or she disagrees with the QIC reconsideration or other determination being appealed. And that would need to be included for each sample claim that the appellant wishes to appeal.

Second, this new regulation – this new section, rather, allows an appellant to wait until he or she receives all – the reconsideration for all of the sample claims appealed at level two – so, at the QIC level – before the 60-day timeframe to request an ALJ hearing begins to run.

So this new provision will help to ensure that all claims can be appealed together that were the sample claims from that group, and they will travel together. They'll be assigned to the same ALJ without an appellant having to worry about missing a filing deadline.

Moving on to slide 45. The third new piece here is that if the appellant does not assert the reason for disagreement was how the samplings were – extrapolation were conducted, 405.1014 and the new issue regulation as well provide that these issues will not be considered or decided.

And then, finally, in 405.1064, the prior one stated that ALJ must – that the ALJ must base his or her decision on a review of the entire sample used by the QIC. And that's had some confusion and differing interpretations by adjudicators as requiring them to review all sample claims, even those that were decided favorably below by the QIC.

So to address this, that section was removed and a new section was added to 405.1032(d)(2). which now states that the review is based on the entire sample to the extent appropriate to decide the issue.

So where a sample claim was adjudicated favorably by the QIC, that claim would no longer be at issue unless the ALJ raises it as a new issue, and then notice would be required to all the parties.

And on that note, I am going to turn it over to Anne Lloyd to tell you a bit about the new OMHA statistical sampling initiative.

### **Statistical Sampling Initiative**

Anne Lloyd: Thank you, Amanda. So, Amanda just finished talking about statistical sampling at the level one or two. I want to talk about statistical sampling at the OMHA level. And what exactly is that?

Well, statistical sampling for us draws a random sample from a universe of claims and extrapolates or projects those results to a – from the sample to the entire universe of claims after the decisions are made on the sample claims.

For example, let us say that you filed a thousand claims with us – and there are people who have – and, as you know, we do have some backlog. So this actually is a way to have all of your claims looked at in one spot at one time.

So you filed your thousand claims. And a statistician reviews those claims and draws a sample, let us say 30 of those claims. You have a hearing on those 30 claims and a decision is made on those claims. And, then, that decision on those claims is extrapolated back to your thousand universe of claims that you started with and it's effectuated on that basis.

And I'll kind of go over that again in perhaps more detail as we go through here. But that's the initial premise for the statistical sampling initiative.

And as I mentioned, we do have a statistician. Actually, we have several statisticians that are hired by OMHA. They are trained and experienced and they do develop the appropriate sampling methodology in accordance with Medicare guidance. And I do

have the publication site on your slide. We're on slide 47. And the statistician will randomly select the sample unit. The Administrative Law Judges are then going to review those sample units and make findings and a decision on those sample units.

So why would you want to do this? A lot of appellants have a number of claims with us. It becomes somewhat burdensome to attend all of those hearings. This does actually streamline the number of hearings that would be attended. It's more efficient.

And we are currently assigning for our appeals that are in our backlog, appeals that we received in the second quarter of fiscal year '14, which would be January through March of fiscal year '14. This is a way to take those appeals, basically combine them with the other appeals you've filed with us, have them heard and decided in a more expeditious fashion.

So how can you have your appeals adjudicate through statistical sampling? There are three basic methods that this can take place through. First, you as an appellant can request statistical sampling. If you look at your claims that you have with us on appeal and think, "Hmm, this might be a good way for me to go," you can refer to our website for quite a bit of information about the Statistical Sampling Program and what would render your appeals eligible. It's on – rather than reading through the entirety here, it is on slide 48.

But, in short, it's also on the [www.hhs.gov/omha](http://www.hhs.gov/omha) website. It's the bottom link on that – or it's one of the bottom initiative links on that page.

In addition, if you have appeals scheduled with an Administrative Law Judge, you can speak with them about it and an Administrative Law Judge can inquire whether you are interested in doing the – or in adjudicating those appeals through statistical sampling and refer them to our Statistical Sampling Coordinator to start investigating the process with you.

And, last, our OMHA Statistical Sampling Coordinator may independently identify likely groups of appeals and get in touch with appellants to enquire whether they are interested in statistical sampling.

In all of these, I would like to point out that statistical sampling is voluntary. You cannot be forced to adjudicate through statistical sampling. It requires your agreement to proceed.

So what – I mentioned that the eligibility requirements are on the website, but I do want to go through them a bit. What appeals and claims are eligible for statistical sampling? And we're beginning slide 49.

The request for hearing must appeal a QIC reconsideration decision. That's a fairly simple one. And the appellant must be a single Medicare provider or supplier. That's a little less simple.

If there are – let me explain it the way I think about it. If there is a parent entity for a number of providers, and each of those providers have a separate NPI as does the parent entity, we can adjudicate appeals for all of those providers as a single statistical sample. However, the parent entity and the provider entities must agree that payment will be going to only one of the NPIs associated with your group. The – and that is one of the things that is worked out at the beginning of the statistical sampling process.

Also, as far as eligibility is concerned, on slide 50, all adjudicational requirements – I'm sorry – all jurisdictional requirements for a hearing before the ALJ must be met for all appeals claims. This would take place regardless of whether they're part of a statistical sample or not. However, if they are part of a statistical sample, we are still going through and looking to make sure that jurisdictional requirements are met.

The beneficiary associated with the claim must not have been found liable after the initial determination nor have participated in the QIC reconsideration. That would – those will be weeded out of any universe for a statistical sample and found ineligible.

On to slide 51. There must be a minimum of 250 claims, and all the claims must fall into only one of -- appeals category. They must all be pre-payment claim denials or post-payment claims – I'm sorry – post-payment, overpayment, non-recovery audit contractor, or RAC, claim denials or post-payment overpayment RAC claim denials from one RAC.

This also is on the website. It does – it's quite a mouthful from my end. But, also, I do want to point out that if you have a large number of appeals and you can meet the 250 claims in multiple categories, we can adjudicate these as multiple statistical samples. It's simply that within a single statistical sample, only one of these categories can be contained.

And also, there cannot be an outstanding request for settlement conference facilitation for the same claims. Settlement conference facilitation is another of our initiatives, and information on that is also on our website. But you can only participate in one of the initiatives at a time.

So on slide 52, you've decided you want your appeals adjudicated through statistical sampling. So what do you expect? What are the next steps? OMHA – we will generate a list of potential appeals and claims to create the initial universe.

We'll also, at that time, do a procedural review for jurisdiction and the statistical sampling criteria. So the list that you receive after that review is – basically has had a first pass for appeals that we believe are eligible.

You would then review that list for completeness. Do we have all the appeals that you believe you've filed with us? Are there appeals on there that you believe are not appropriate or not eligible to be part of the statistical sample? I would, however, like to point out that it's – to put it bluntly, you can't cherry-pick your appeals. If they qualify, they will be part of the statistical sample.

Then, a pre-hearing conference is held by an Administrative Law Judge to discuss and finalize that universe. If you have concerns about what's in that statistical universe or the sample universe, the -- that pre-hearing conference is your opportunity to discuss those with an Administrative Law Judge. The Administrative Law Judge, at the same time, will review the process that you can expect and answer any questions you might have.

After the pre-hearing conference, the Administrative Law Judge is going to issue a conference order. Within a defined time, if there is no objection to the conference order, that order becomes binding. And at that point, you have agreed to have your

universe adjudicated through statistical sampling. That is, in fact, the last opt-out option you have.

On slide 53, the next step is the appeals will be combined and assigned to a Lead Administrative Law Judge for hearing. And this actually is a – what I'm going to describe next is a new portion to this.

This is not the first rollout for the statistical sampling initiative. However, we did listen to appellant feedback as we looked at this program, and we have expanded the Administrative Law Judges that will be reviewing the statistical sample.

So, in addition to the Lead Administrative Law Judge, depending on the size of your universe, you will receive a cadre of additional Administrative Law Judges. So if the universe is size 250 to 750 claims, two additional Administrative Law Judges will be assigned. And in that particular case, each one of those Administrative Law Judges will hear and decide one-third of the statistical sample claims.

If the universe is 750 claims or greater, a cadre of three to four additional Administrative Law Judges will be assigned. And in that particular case, each of those Administrative Law Judges would hear and decide a quarter or a fifth of the statistical sample claims. The – each – and as I mentioned, each of them will conduct a hearing on those – their portion of the sample unit and decide on that portion.

So during your hearing with the Lead Administrative Law Judge on that portion of the sample unit, in addition to discussing the merits of your claims, you may also discuss the sample methodology, question the OMHA statistician, and, if you wish you, you may bring your own statistical expert. That only takes place with the hearing with the Lead Administrative Law Judge.

So after each of those Administrative Law Judges decides their portion of the claims, the Lead Administrative Law Judge combines the decisions of each of them on each of those claims and basically begins to write your decision.

After – at that point, the decision on the sample unit will be extrapolated to the universe of claims by the OMHA statistical expert. And that is then included in -- as part of your decision, and your decision is issued. After the decision is issued, CMS

contractors apply payment amounts and effectuate those payments of the claims based on the extrapolated amount. And that was slide – I’m sorry – 55.

Moving on to slide 56. So, do you have appeal rights after the decision on the statistical sample? Yes, you do. But bear in mind that these appeals have all been combined into one decision and you are appealing the ALJ decision. All the claims included in the statistical sample universe must be appealed. They have to travel as one package administratively. In addition, the statistical sampling methodology may be appealed for the entire sample universe as well.

On slide 57 – so how does this differ from the initial sampling – statistical sampling pilot that I just mentioned? One of the, I think, really great things is there is no longer a filing date range restriction. When we first rolled this pilot out, there was a very limited period of appeals that could be considered for statistical sampling.

Currently, all of your eligible appeals will be included in the statistical sampling universe. And as I also just mentioned, your appeals will be heard and decided by multiple adjudicators. As I said, one of the common concerns was having a single ALJ decide the entire statistical sample. And this kind of spreads out the number of ALJs that you will be working with and that will be making decisions on your claims.

And that is our new and updated statistical sampling initiative. And we hope to hear from you. In the – in the next couple of slides, we did actually put the statistical sampling mailbox. If you have an interest, please get in touch with us.

Jason Green: Thank you, Anne.

And, now, we’re going to turn it back over to the moderator for questions and answers.

## **Question and Answer Session**

Charlie Eleftheriou: Yes. Thank you for that very informative presentation.

Our experts here now will take your questions. But before we begin, I’d like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. And in an effort to get to as many participants as possible, we ask that you limit your questions to just one at a time.

All right. I think we're ready to take our first question on the line.

**Operator:** To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Courtney Tito.

Courtney Tito: Hi. I was just wondering if there's been any discussion about expanding the settlement conference facilitation?

Anne Lloyd: There has been. I think that in – we've actually had a pretty terrific response on settlement conference facilitation and, honestly, processed it with a fairly limited staff. It's an additional initiative for us. So, yes, we are talking about it. And at the point where we do expand it, we will, I suspect have another open door call to let you know about it. But at this point I don't have expansion information for you.

Jason Green: Can I just quickly ask the caller a question? What area would you – are you interested in expanding to?

Courtney Tito: I just meant additional dates. Because last I checked, it was still for prior to 2015, unless I missed it.

Anne Lloyd: That is, in fact, under consideration.

Jason Green: Thank you.

Charlie Eleftheriou: Thank you. We'll take the next question.

**Operator:** Your next question comes from the line of Nick Alarif.

Nick Alarif: Hi. This is Nick Alarif with McDermott Will and Emery. First of all, I just wanted to thank OMHA for hosting this. It's been really informative. My question is regarding just the new cadre of judges and how it will – will we find out or would an

appellant find out at the initial conference who the cadre of judges helping to lead ALJ be?

And would one opinion be issued or would multiple opinions from each of the cadre of judges be issued regarding the statistical sample? Thank you.

Anne Lloyd: No. At the pre-hearing conference, judges are not yet assigned. Until that order is binding, the judges will not be assigned to the appeal, or vice versa, the appeal would not be assigned to the judges. And other question was...

Jason Green: Is it a single opinion?

Anne Lloyd: A single opinion? Yes, it is. It's – basically, the decisions of each of the judges are integrated individually. So they're opining on each one of the claims that they heard and that part, their exact decision on each of those claims is integrated into the final decision. But it is a single decision.

Nick Alarif: Great. Thank you very much.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question comes from the line of Basil Casteleyn.

Basil Casteleyn: Yes. I'd like to thank the panel for the informative training here today. My question's pretty basic. We've had claims that have been scheduled before the ALJ since May of 2015 with virtually no communication.

Would you suggest that we do something a little more proactive with the OMHA-100 and see if we can get these balance of claims, which are basically 32 individual claims with home health care and their one episodic in nature?

So we had one determination, a reversal of 14 claims. And then we have the balance of these 14 claims that are up for review before the ALJ with little or no communication whatsoever.

Amanda Axeen: Hi. This is Amanda. Can I just ask you to repeat – did you say that you had filed in 2015?

Basil Casteleyn: Yes. We filed back in 2015, had one hearing in May of 2015. Of the – originally, the claims that went up were 64 claims between one and two episodics -- claims and history, and then no communication since then and QIC program integrity determination. So our issue is primarily one of just getting access to an ALJ to review the balance of our claims.

Amanda Axeen: Sure. So, I just want to explain a little bit. So the – it's possible that your appeals have not been assigned to an ALJ.

Basil Casteleyn: Correct.

Amanda Axeen: We assign beneficiary cases out to judges upon receipt. But appeals initiated by providers and suppliers and Medicaid State agencies are remaining in kind of a first in, first out situation. So they're being held by the date they were filed.

So right now we're actually assigning appeals that were received in – through the third quarter of fiscal year 2014, which is through June 30<sup>th</sup>, 2014. And, so, if your appeal is just filed after that date, it's really just in line waiting for assignment. But you can check using either the Medicare appeals number if you have the QIC number or the ALJ number.

Basil Casteleyn: Yes.

Amanda Axeen: You can use either of those to check the status of your appeal online on our website using...

Basil Casteleyn: Okay.

Amanda Axeen: ... a system called AASIS. It's the ALJ Appeals Status Information System. And, again, you can – there's a link to it right on our homepage, which is [hhs.gov/omha](http://hhs.gov/omha). And so you can check and, hopefully, that would be able to tell you.

If your appeal is unassigned, it would just let you know that we received it and the date that we received it. But if it is assigned, it would provide the judge team contact information.

Basil Casteleyn: Oh, okay. And could you repeat that acronym of the system?

Amanda Axeen: Sure. I'm sorry. It's the ALJ Appeals Status Information System or AASIS – A-A-S-I-S. But, really, I think it's something more plain language, too, on our homepage. It says, "Check the status of your appeal" or something like that.

Anne Lloyd: I think it's one of the first links on the top of the list that's on the right-hand side of the homepage.

Basil Casteleyn: Okay. Very good. So, it's best just to query that and then those – our claims are then, you know, they're put in the queue and then eventually get on a docket somewhere. Is that correct?

Amanda Axeen: Yes.

Basil Casteleyn: Okay. Thank you very much for the information. Very helpful.

Amanda Axeen: Thank you.

Charlie Eleftheriou: You're very welcome. Just a reminder. We'd like to try to take one question at a time from folks. After we answer your initial question, you can press star, one to get back in the queue and we'll follow up with additional questions as time permits.

We'll take the next question.

**Operator:** Your next question comes from the line of Kate Stinneford.

Kate Stinneford: Hi. Hello. Can you hear me?

Charlie Eleftheriou: Yes, we can.

Kate Stinneford: Okay. This may be because I'm no statistician. But, I guess I'm finding it hard to understand how the three eligibility categories – how they can be similar

enough to each other to really determine by looking at a sampling that all of them would be following the same sort of pathway.

You know, if one is for denial of one thing and something else is for denial of another, then my – related to that is what happens if you have a \$750 sample or 750 claim sample and the three different judges come up with widely differing percentages?

Anne Lloyd: That's actually an excellent question. And let us say – for easy arithmetic, let us say that there were two ALJs and let's say that the first one found – and I'm – this has nothing to do with real life but I want to make it as easy as I can to explain.

And one of the judges found everything favorable and one of the judges found nothing favorable. Essentially, when that's extrapolated in the simplest terms to the universe, you would end up with a 50-percent payout.

Kate Stinneford: But wouldn't you sort of wonder if maybe one of them was interpreting it wrong if they're that opposite from each other?

Anne Lloyd: No. That was just an example. I mean, that is – I would say fairly unlikely. But it was the example in terms of how that percentage is applied. If you want it more real life, let us say that they find that overall across the entirety of the judges that review it, they find that 60 percent of your claims are favorable.

That 60 percent as the statistician would go in in a much more complex way, I'm sure, would then be applied back to your universe. It's a percentage extrapolation.

Charlie Eleftheriou: Thank you. Next question, please.

**Operator:** Again, in order to ask a question, please press star followed by the number one on your telephone keypad. To remove yourself from the queue, please press the pound key.

Your next question comes from the line of David Simon.

David Simon: Hi. Thanks for the presentation information. I appreciate it. In the case of a cadre of judges where there's a large sample universe, does that mean that, for example, five judges will hold five hearings or will all five judges be present for a single

hearing? And I know I'm only supposed to ask one question, but how does that apply to in-person hearings?

Anne Lloyd: If, there's – all right. Let me do these one at a time. The – each of the judges will conduct a separate hearing. And so you will end up with five hearings.

On the other hand, if you had a thousand appeals, five is probably better than a thousand hearings. And in terms of – if you were to have an in-person hearing, we are selecting the cadre of judges from the same office as the Lead ALJ.

David Simon: I see. Okay. Thanks a lot.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question comes from the line of Linda McCauslin.

Linda McCauslin: Hello. This is Linda McCauslin with Medical Facilities of America. It is very useful to hear you say that you are scheduling requests that were received in – as I understand, second quarter of 2014.

My question is I have several appeals that I show as having the request been mailed prior to that and we have not yet received notice that they've been assigned to a judge. So, what is the best way for us to follow up and make sure that those appeals are somewhere in the queue?

Amanda Axeen: Hi. This is Amanda. The best way, since that's really specific to your individual cases, if you look in AASIS, that online lookup tool that I had just mentioned, there's an appeals status lookup you can put in your numbers and you may see that – if you can confirm that it hasn't been assigned but you're beyond that date frame, feel free to give us – you can email us.

You can contact us directly at [medicare.appeals – plural -- @hhs.gov](mailto:medicare.appeals-plural@hhs.gov). So, that's [medicare.appeals – A-P-P-E-A-L-S@hhs.gov](mailto:medicare.appeals-A-P-P-E-A-L-S@hhs.gov) with a specific – you know, if you have appeal numbers, definitely include those. And we can work with either QIC reconsideration numbers or the ALJ numbers if you have them.

And if you do have information also about the dates on which you filed them and, you know, you're concerned about the delay we would be happy to look further into your specific case.

Linda McCauslin: Thank you.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question comes from the line of Alisha Tamata.

Charlie Eleftheriou: Hello, Alisha. Are you with us? We can try the next question, please.

**Operator:** Your next question comes from the line of Sarah Mendota.

Sarah Mendota: Hi. Sorry. Caught me by surprise there. I just have a question really about postponements and objecting to the time and place of hearing. For some reason, as of late when we've been trying to get a postponement for whatever reason, the ALJs have been kind of unwilling to do that, and we've been getting a lot of questions like "Well, don't you have somebody else to conduct the hearing?" So it's more of a statement but also a question. Do we have any recourse in those situations where we really can't attend the hearing that particular day, but the ALJ just doesn't seem to want to, you know, give us any wiggle room there?

Jason Green: On that issue, the ALJ really has sole discretion about the time and place of hearing. So you would need to work with your assigned ALJ on that.

Sarah Mendota: So, even if we present them with good cause, it's really up to their discretion as to what they consider good cause to be?

Jason Green: That's correct.

Sarah Mendota: Okay. Great. Thanks.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question comes from the line of Tracy Field.

Tracy Field: Hi. I just had a question in terms of the statistical sampling initiative. I understand the percentage assignments extrapolated out for the values in terms of once a decision is made. How does that work in terms of if it impacts a number of inpatient versus outpatient days or is that also part of that determination? Are you ever going to end up having to split the number or the number of inpatient days can impact cost reporting and other issues? Thank you.

Jason Green: For the statistical sampling, if they involve that sort of matter, what you would need to know is that the universe of claims – the status of the claims not in the sample are not going to change.

So for those cost reporting purposes, those – the universe of claims – again, those not in the sample, the status will remain denied and whatever the effects on cost reporting are would remain as denied.

Tracy Field: So I could still win the dollars but I'm not going to get the count credit for an inpatient day?

Maria Ramirez: Hi. This is Maria Ramirez. We wouldn't – we don't have really the expertise in the room to answer that question. That would be something to discuss with OFM, and there's nobody here at this time.

Tracy Field: Thank you.

Charlie Eleftheriou: Thank you.

**Operator:** Our next question comes from the line of Taryn Shraad.

Taryn Shraad: Hello. This is Taryn with Lawrence Memorial Hospital. My question is if a provider elects to adjudicate these appeals with this statistical sampling and we win, will we not only get the refund of our overpayment but the interest that has accrued with these cases that have languished for years?

Maria Ramirez: Hi. This is Maria Ramirez again. That's a question that you should probably submit in writing as well as the one that Tracy Field was just asking. I'd like to share with you a mailbox. If you wouldn't mind, please sending your question in writing,

we will coordinate a response from OFM on that regarding the interest and the cost reports. It is medicare – F as in Frank, F as in Frank S appeals@cms.hhs.gov.

Taryn Shraad: Can you repeat that, please?

Maria Ramirez: Sure. Medicare F as in Frank, F as in Frank, S as in Sam appeals@cms.hhs.gov.

Taryn Shraad: Okay. Thank you.

Maria Ramirez: Thank you.

**Operator:** Your next question comes from the line of Jill Robinson.

Mary Masai: Yes. This is Mary Masai from Hennepin County Medical Center in Minneapolis. And I just had a question on the timing. If we have a case that is being assigned to an ALJ, I believe we would receive a letter to notify us to that effect.

And how long would the timeframe be from when we receive notice that you've assigned it to when the judge would actually hold a hearing?

Jason Green: That, again, is going to depend on the individual judge. So, the – once you get the notice of assignment that your appeal has been assigned to a judge, the judges do have varying dockets.

So it will be scheduled as quickly as possible for that particular judge. Obviously, you can contact that judge's team to find out – get a better estimation of when they might be able to get that on the hearing docket or get that case reviewed to do that.

Anne Lloyd: And I would also like to point out if you're looking these up on the AASIS website that Amanda mentioned, that gives you – once it's assigned, it gives you your judge's name. But it also gives you a team number of you want to follow up with that.

Charlie Eleftheriou: Thank you.

Jason Green: Thank you, Mary.

**Operator:** Thank you. And as a reminder, to ask a question, please press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Your next question comes from the line of Courtney Tito.

Courtney Tito: Hi. I may have missed this in the presentation. Thank you for letting me do a second question. Was, I know that we talked about appeals on the statistical sampling initiative and whether the provider or the beneficiary could appeal. Can CMS or the Medicare Appeals Council or anybody else appeal as well from that decision?

Jason Green: So the standard Council review rules would apply, which would allow for CMS to refer the case to the Council. And then the Council has the discretion to act on that and review a case on its own motion.

Courtney Tito: Thank you.

Jason Green: So that rule still applies.

**Operator:** Your next question comes from the line of Neisha Tonata.

Neisha Tonata: Hi. This is Neisha Tonata. I'm calling regarding claims we had issued with the credentials.

Charlie Eleftheriou: I'm sorry. If you could speak up a little tiny bit. We're having a hard time hearing you on our end.

Neisha Tonata: Okay. Yes. My question is regarding the credentials. We had credential issue. We sent the claims and they were denied, the providers were not contacted. So, we sent the appeal also that they were contacted after like 5 to 6 months.

So during that period – during the – due to the nature of the business, which was hematology/oncology, providers had to provide the services because patients were on chemo. So they paid out of their pocket for all the drugs and everything and, still the claims are pending for those. What forms do we need to send it to appeal those?

Jason Green: That's a pretty specific question. And, unfortunately, it's not clear to us where – what the denial basis is, if it's related to the credentials...

Neisha Tonata: Denials were – the denials were the provider was not credentialed.

Jason Green: Okay. So I'm going to suggest you contact CMS on that. And you can send an email to the address Maria provided earlier, which is medicareffsappeals@cms.hhs.gov.

Neisha Tonata: Okay.

Jason Green: Again, medicare F as in Frank F as in Frank S as in Sam appeals@cms.hhs.gov.

Neisha Tonata: I got that. I will do that.

Jason Green: All right. Thank you.

Neisha Tonata: Thanks.

Charlie Eleftheriou: Thank you.

**Operator:** As a reminder, to ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Your next question comes from the line of Nick Alarif.

Nick Alarif: Hi. Thanks for fielding another question from me. I was just wondering how the statistical sampling pre-payment tier judge with the current regulations that apply to statistical sampling in other contexts, you know, namely, you know, 405.1014(a)(3) and 405.1032(d) and if the same principles will govern statistical sampling in this context.

Jason Green: So, Nick, if I can try and rephrase your question a bit.

Nick Alarif: Sure.

Jason Green: You can tell me if I get it right.

Nick Alarif: Okay.

Jason Green: So, you're wondering about how the rules related to statistical sampling that is appealed to OMHA relate to our initiative?

Nick Alarif: Correct.

Jason Green: Okay. So, CMS does not do pre-payment sampling as far as we're aware. So those do not come up to us. However, in our initiative here at OMHA, we can do pre-payment sampling.

So I think you will see a disconnect in the rules regarding the appeals to OMHA and some of our initiative language because we have that additional feature here where we're including pre-payment appeals in our sampling initiative. Is there a specific provision that's causing confusion for you?

Nick Alarif: No. I was just trying to make sure we have all of the correct items available in the pre-payment context for statistical sampling...

Jason Green: Okay.

Nick Alarif: ... and if there might be any overlap for that guidance.

Jason Green: Okay. And, generally, our process is going to follow CMS's ...

Nick Alarif: Right.

Jason Green: ... sampling and extrapolation process. But, obviously, there will be a few differences based on its pre-payment...

Nick Alarif: Correct.

Jason Green: ...and post-payment nature.

Nick Alarif: Of course. Thank you very much.

**Operator:** Your next question comes from the line of Richard Klemmer.

Richard Klemmer: Hello.

Charlie Eleftheriou: Yes. We're with you.

Richard Klemmer: Hello. Great. Yes. My question is I'm – was looking at the Medicare Managed Care Manual, the provider manual. In Chapter 11 of it, there's a statement that says the contractors must comply with all requirements governing coverage determinations, grievances, and appeals.

And I was wondering if that language would – if that would then permit an Advantage plan to vary from what traditional Medicare's appeals process is, for example, charging the provider a fee in the event that the medical review request is unfavorable to the provider or limiting the number of appeals like redetermination and reconsideration ALJ, instead just saying, "You have one opportunity to appeal and then you have to go to a medical review. And if you lose that, you have to pay an extra \$350."

Are there different standards for the Advantage plans? Or does this statement in Chapter 11 here, as I'm interpreting it, mean that they're supposed to be following the same guidelines that a traditional plan would? Thank you.

Jason Green: Thanks for the question. Unfortunately, we really can't answer that. We're really focused on the ALJ level of appeal and the procedures here. So, if you have questions about something you're experiencing or the Medicare Advantage plan, again – I don't mean to sound like an echo chamber here, but I would need you to ask or pose that question to the email address that Maria provided, medicareffsappeals@cms.hhs.gov.

While that does stand for Fee-for-Service, they also deal with the Medicare Advantage and Part D plans as well. So, just pose your question to that.

Richard Klemmer: Okay.

Jason Green: They'll put you on the right track. Thank you.

Richard Klemmer: All right. Well, thank you.

**Operator:** Your next question comes from the line of Tara Khune.

Tara Khune: Hello. I've had some recent instances where judges have not been doing swearing in of testimony. Generally, that's always been the procedure probably in 95 percent of the claims.

But, the last two that I've done, the judges have just said, "No, you're just providing information – providing like a statement – a position statement. You're not providing testimony." But I have not been able to find that in any of the regulations. Is that something new that's coming up that they have been directed to do? Or what's the situation with that?

Jason Green: They've not been given any direction on that. That's – you know, the judge controls the course of the hearing. And some judges might, as a routine course of action, swear you in so that if you happen to provide testimony, you're already sworn in. Other judges wait for that. And they might take arguments and position statements. And if they don't see the need to do any sort of swearing in, they might not have the opportunity to do so in the course of a hearing. So, if they're posing questions to you sort of their – how they're characterizing your feedback. Does that make sense?

Tara Khune: Well, I just worry going down the road that if it's supposed to be recorded testimony and on the record for further questions, that then there's nothing recorded, there's nothing to validate what was said at the hearing.

Jason Green: It's all still recorded. It's all part of the official record. So ...

Tara Khune: Okay.

Jason Green: So, it is – the audio of that hearing is made part of the official record and it is reviewed by the Council if it goes to the Council or Federal court if it goes to the Federal court.

Tara Khune: Okay. All right. Thank you.

Jason Green: Thank you.

**Operator:** And there are no further questions at this time.

## **Additional Information**

Charlie Eleftheriou: All right. Well, I guess we will then end this call a little bit early today. If you have a question and were not able to get it in, please see slide 59 for resources and email addresses that you can use to submit additional questions.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects newsletter when they are available.

On slide 61 of the presentation, you'll find information and a web address to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your experience with us today.

I would to thank our presenters and everyone who participated in today's MLN Connects Call. We hope you have a great day.

**Operator:** This concludes today's call. Presenters, please hold.

-END-

