Low Volume Appeals Settlement Option Call

Moderated by: Hazeline Roulac
January 9, 2018—1:30 pm ET

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I would now like to turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements & Introduction

Hazeline Roulac: Thank you, Dorothy. Hello, everyone. Thank you for joining us today. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I am your moderator for this call. I would like to welcome you to this Medicare Learning Network call on the Low Volume Appeals Settlement Option.

As part of the broader HHS commitment to improving the Medicare appeals process, CMS will make available a settlement option for providers and suppliers with fewer than 500 appeals pending at the Office of Medicare Hearings and Appeals and the Medicare Appeals Council at the Departmental Appeals Board.

During this call, CMS subject matter experts will review the low volume appeals settlement option and how the settlement process will work. You will learn how to identify whether you are eligible and which of your pending appeals may be settled.

This call will not include a question-and-answer session, which means we will not be taking questions after the presentation. However, as part of the registration process for this call, you were able to email your questions in advance. We want to thank everyone who submitted questions, which help to inform today's presentation. Following the presentation, our subject matter experts will respond to frequently asked questions.

There is a slide presentation for this call. A link to the presentation was included in your confirmation email. If you haven't already done so, you can download the presentation from the CMS website at go.cms.gov/npc. Again, that's go.cms.gov/npc.

At this time, it is my pleasure to turn the call over to our first speaker, Ronke Fabayo.

Presentation

Ronke Fabayo: Thank you, Hazeline. Good afternoon, everyone, and thank you for participating on this National Provider Call to discuss the low volume appeals settlement option. Thank you for your interest.

My name is Ronke Fabayo, and I am the Deputy Director for the Division of Medicare Debt Resolution in the Office of Financial Management. With me today is Casey Welzant. Casey is the Health Insurance Specialist in the Division of Medicare Debt Resolution.

Moving on to slide 2, the agenda for this call includes a discussion of the settlement background, eligibility, settlement process, and a review of frequently asked questions.

Low Volume Appeals Settlement Option

Moving to slide 3. As part of the broader department commitment to improving the appeals process, CMS is making available the low volume appeals, or LVA, settlement option for appellants with pending appeals at the Office of Medicare Hearings and Appeals, which is the third level in the Medicare appeals process, or at the fourth level, which is at the Medicare Appeals Council at the Departmental Appeals Board. Through the LVA option, appellants can settle their outstanding appeals for timely partial payment of 62 percent of the net approved amount of the appeal.

Eligibility for Settlement

Moving to slide 4, so who's eligible for this settlement option? You may be eligible if you are a Medicare Part A or B provider, supplier, or physician, if you have less than 500 appeals pending at OMHA and the Council levels, keeping in mind that less than 500 has to be across all of your associated NPIs, or national appeal provider identifier numbers, and those said appeals must have been filed at OMHA or the DAB or Council as of November 3rd, 2017.

You are not eligible for the LVA option, however, if you are a beneficiary, enrollee, or family member, or an estate for a beneficiary. If you are a Medicaid state agency, you're also not eligible if you're a Medicaid – Medicare Advantage organization or Medicare Part C or D plan sponsor or, finally, if you're currently in bankruptcy or expect to file bankruptcy.

In addition, please note some appellants may be excluded from participation in the LVA settlement option if that appellant is involved in a False Claims Act litigation or investigation or any other program integrity concerns, including pending criminal, civil, or administrative investigation.

Moving on to slide 5, which appeals are eligible for the LVA? Again, the appeal has to be pending before OMHA or the Council as of November 3rd, 2017.

The billed amount for the appeal has to be $9,000 or less. We received a few questions on this criterion and would like to clarify that the amount is based on the bill amount, not the allowable amount.

Third criterion – the appeal must be filed timely at OMHA or the Council. All of the claims included in the appeal must be in a denied – must have been denied by a Medicare contractor and must remain in a fully denied status in the Medicare appeals system. The claims associated with the appeal were submitted for payment under Medicare Part A or B. The claim – the claims in the appeal were not part of an extrapolation. The appeal, again, must be pending at OMHA or the Council on the date of the Administrative Agreement for the LVA settlement – on the date that that Agreement is fully executed – excuse me.

I'm going to turn it over now to Casey Welzant to walk you through a couple of – the next couple of slides.

Casey Welzant: Thank you, Ronke. We are now on slide 6, which is Initiating the Settlement.

In order to initiate participation in the LVA process, please go to our website go.cms.gov/lva and find the Expression of Interest, or EOI, document. Once completed, the EOI should be submitted to our settlement email, which is cmsmedicareappealssettlement@cms.hhs.gov.

****Post-Call Clarification****
The correct email address is medicareappealssettlement@cms.hhs.gov "Once completed, the EOI should be submitted to our settlement email, which is medicareappealssettlement@cms.hhs.gov."

This email address is provided for you at the end of our presentation. The subject line of that email should have your appellant name, dash, the appellant NPI, dash, the words "Expression of Interest."

Only one Expression of Interest is to be completed per National Provider Identifier, or NPI. If your NPI ends in an even number, you should submit your EOI to us between February 5th and March 9th. If your NPI ends in an odd number, you should submit your EOI between March 12th and April 11th.

If you are a provider or a supplier with multiple NPIs, you should submit one Expression of Interest per NPI during the allotted timeframe. If you do submit your EOI during the wrong timeframe, CMS will not hold it. We will reject the submission and request the EOI be resubmitted during the correct timeframe.

Settlement Process Walk-through

Now I'll move on to slide 7. Once CMS receives the EOI, we will do some eligibility checks. We will be verifying, as previously mentioned, that the EOI was submitted during the correct timeframe. We will also be checking that you meet the appellant eligibility criteria Ronke went over previously, as well as verifying you have appeals that are eligible for settlement.

If you do not meet our eligibility criteria, CMS will notify you within 30 days of submitting your EOI along with the reason that you are not eligible. If you believe our decision is in error, you can dispute the appellant eligibility via the Eligibility Determination Request, or EDR, process we'll discuss a little later. If you pass the eligibility review, you will receive an Administrative Agreement and Spreadsheet of potentially eligible appeals within 30 days of submitting your EOI.

Let's move on to slide 8. Once you receive the Agreement and Spreadsheet from CMS, please review the Spreadsheet for accuracy. And if you are in agreement with the listed appeals, sign the associated Agreement and send back to CMS within 15 days of receiving the Agreement and Spreadsheet. In order to return the signed Agreement, please reply to the email in which you received the Agreement and Spreadsheet.

If you disagree with the Spreadsheet you received, meaning that you believe some eligible appeals are not included or some of the appeals listed are not eligible, you should submit an EDR within 15 days of receipt of the Spreadsheet and Agreement. This should also be submitted as a reply to the email in which you received the Agreement and Spreadsheet.

Now, will we – we will move on to discuss how and when to complete the EDR on slide 9. The EDR document, as well as instructions for completing it, are available on our website go.cms.gov/lva.

In order to dispute appellant eligibility, meaning when CMS received your EOI, we responded by stating that you were not eligible because you did not meet our appellant eligibility criteria or for another reason. The EDR is a spreadsheet and, for appellant eligibility disputes, you should fill out the second tab of this EDR document. Once completed, this document should be sent to CMS within 15 days of when you received CMS's appellant eligibility decision. Once we receive the EDR, we will review the document and any associated documentation and make a decision within 30 days of receiving your EDR.

If you are determined to be eligible after CMS's review, we will send you an Administrative Agreement and Potentially Eligible Appeals Spreadsheet. If CMS determines that you still do not meet eligibility criteria after the review, you will be notified and removed from the settlement process.

Slide 10 provides a list of the required information in order to complete the Appellant Eligibility Dispute tab on the EDR. So, let's take a look at that now. The data fields include the appellant name, NPI, appellant point of contact name, appellant point of contact telephone number and email, appellant tax identification number, or TIN, corrected TIN if applicable, and your reason for disputing the eligibility.

An example of a completed EDR for appellant eligibility can be found on slide 11. This appellant looks to have been excluded because they were associated with a TIN that had more than 500 appeals pending at OMHA and the Council. So, this appellant is stating they had a change of ownership and are no longer associated with the TIN that we have them on record being associated with and, therefore, are eligible for settlement because they have less than 500 appeals.

If you are disputing appellant eligibility, please provide any documentation to support your reason for dispute. The more information you have to support your position, the better.

Next, we'll move on to slide 12, which discusses completing an EDR for appeal eligibility. Disputing appeal eligibility would mean engaging the EDR process after you receive your Agreement and Spreadsheet and you do not agree with the Spreadsheet, meaning either appeals are missing or some appeals are included that should not be. The EDR for this situation should be submitted to CMS within 15 days of receiving the Agreement and Spreadsheet. Once we have received your EDR, we will work with you and your associated Medicare Administrative Contractor, or MAC, to resolve any discrepancies within 30 days of receiving your EDR.

We do note that CMS retains the right to make the final eligibility decision on these appeals. And also, you may only submit one EDR for appellant eligibility and one EDR for appeal eligibility for each NPI. So please be sure to include any and all appeals you wish to dispute, as well as any supporting documentation you have.

At the end of the EDR process, the appellant will be provided a final Spreadsheet. If they are now in agreement with that Spreadsheet, they should sign their Administrative Agreement within 15 days of receiving the final eligibility determination and Spreadsheet from CMS. If at the end of the EDR process the appellant disagrees, they can abandon the settlement process and keep all of their appeals in the traditional appeals process or can continue to settle the appeals CMS has determined to be eligible.

An example of the information you need to complete the EDR tabs related to appeal eligibility can be found on slide 13. If you are requesting to add appeals, please populate as many of the fields as possible. If you are

requesting to remove appeals, please populate the information directly as it appeared on your Spreadsheet. There is one tab for appeal addition and one tab for appeal removal. Make sure to list all claims included in the appeals you are adding.

The fields we are requesting to be populated include appellant name, NPI, appellant point of contact, appellant point of contact's phone number and email, active appeal number, the level the appeal is currently pending at, meaning the ALJ or Council, the associated ALJ number if applicable, the QIC appeal number, and then all associated claim numbers and associated dates of service, also the reason for wanting to add or remove the appeal.

An example of a populated EDR for appeal eligibility can be found on slide 14. Here, the provider is requesting to remove the appeal because they have since received a decision on one of the appeals listed on their Spreadsheet; therefore, this appeal is no longer eligible for settlement. As I stated with the appellant eligibility, please provide as much documentation as you can to support your position. It will allow us to work these much quicker.

Moving on to slide 15, here are a couple of important facts to know about this settlement process. The first two bullets are related. You must settle all eligible appeals. You cannot choose to settle a handful of eligible appeals using LVA and keep the other appeals in the appeals process. Any and all appeals that meet eligibility criteria must be settled.

Another very important note is that there is a 15-day window for you to take action at each step in this process. If you are not responsive to CMS within 15 days of receiving your Agreement and Spreadsheet or EDR Eligibility Determination, we will consider you to have abandoned the process and will remove you from settlement. We understand things happen and, for one reason or another, you may not be able to complete some action within the 15-day timeframe. If this is the case, we just ask that you let us know and work with us on the issue. We will work with you or – if you are being responsive. So, please keep us in the loop about any problems if you wish to continue the settlement process.

Now we'll move on to slide 16 where we will discuss the final steps of the settlement process. Once we receive your signed Agreement, we will sign it and a copy will be sent to you. At this point, any appeals included in the Spreadsheet will be stayed and removed from the active appeals process.

A copy of the fully executed Agreement and associated Spreadsheet will also be sent to your MAC for final eligibility verification and pricing. There is a chance that during this MAC eligibility review, appeals will be removed from settlement for not meeting the eligibility criteria. If this occurs, you will be notified.

Payment will be made to you within 180 days of CMS's signature on the Agreement. You will also receive a price spreadsheet that shows you which appeals are included in the payment and how they were priced. Any appeals paid as part of settlement will be dismissed at this point, and any appeals that are unsettled, if any, will be returned to their place in the appeals queue and retain their appeal right.

At this point, I will turn it back over to Ronke to go over some of our frequently asked questions.

Review of Frequently Asked Questions

Ronke Fabayo: Thank you, Casey. Now I'm going to go over some of the frequently asked questions. I'm on slide 17. To assist me, I have my colleague Morris Plater. Morris will read the questions and I will provide the responses. Morris?

Morris Plater: Hello, everyone. What if an appellant has an odd and an even NPI? When does the appellant submit its EOI?
Ronke Fabayo: If an appellant has one even NPI and one odd NPI, the appellant must submit one EOI for the even NPI between February 5th, 2018, and March 9th, 2018, then one EOI for the odd NPI between March 12th, 2018, and April 11th, 2018.

Morris Plater: Question 2. Who is authorized to sign the Administrative Agreement on behalf of the appellant?

Ronke Fabayo: The person who executes the Administrative Agreement represents and warrants that they are fully authorized to sign on behalf of the appellant.

Morris Plater: Question 3. How long will it take CMS to complete the settlement?

Ronke Fabayo: CMS and its contractors will work expeditiously to create the Eligible Appeals Spreadsheet. Once the appellant validates the Spreadsheet and returns the signed Administrative Agreement, CMS will countersign and effectuate payment within 180 days of CMS's countersignature.

Morris Plater: Question 4. What happens if we do not proceed with the settlement after submitting an EOI?

Ronke Fabayo: The settlement participation is completely voluntary. Appellants who do not wish to proceed with settlement after submitting an EOI will remain in the normal appeals process.

Morris Plater: Question 5. Can appeals of extrapolated overpayments that otherwise meet eligibility criteria be settled under this process?

Ronke Fabayo: No, appeals resulting from extrapolated overpayments are not eligible for this settlement.

Morris Plater: Question 6. Is the settlement for both Medicare fee-for-service and Medicare Advantage cases in the appeal process?

Ronke Fabayo: This settlement is only for eligible claims submitted for payment under Medicare fee-for-service.

Morris Plater: Question 7. Will appellants know the net settlement value of the included eligible appeals before they sign the Administrative Agreement?

Ronke Fabayo: No, the net settlement amount for an appellant will not be available before the Agreement is signed. The net settlement amount will be determined after the Settlement Agreement has been signed by both parties. CMS's MAC priced each claim individually. The settlement percent – the settlement percentage will be 62 percent of the net claim approved amount.

Morris Plater: Question 8. Can I edit or add column fields to the Eligible Appeals Spreadsheet?

Ronke Fabayo: No, appellants may not add columns or reformat the Spreadsheet. If appellants make changes to the Spreadsheet, CMS will reject the Spreadsheet and the appellant will have to restart the EOI process.

Morris Plater: Question 9. Is the fewer-than-500-appeals limitation applicable to each of my NPIs? What if I have multiple NPIs?

Ronke Fabayo: The fewer-than-500-appeals limitation refers to the number of appeals collectively across all NPIs that belong to an appellant. For example, if an appellant has 6 NPIs and 100 appeals pending for each NPI, the appellant has 600 appeals pending in total and, therefore, it is ineligible to participate in the LVA process.

Morris Plater: Question 10. In order to participate, must an appellant have fewer than 500 appeals that have billed amounts of $9,000 or less? Or must an appellant have fewer than 500 appeals pending in total and, of those, CMS will settle the ones that have billed amounts of $9,000 or less.

Ronke Fabayo: This option is available for appellants with fewer than 500 appeals pending collectively at OMHA and the Council. Once CMS confirms that an appellant has fewer than 500 appeals, CMS will settle those eligible appeals with a total billed amount of $9,000 or less.

For example, if an eligible appellant has 450 appeals pending at OMHA and 10 appeals pending at the Council, the appellant has 460 appeals pending collectively. If 400 of those 460 appeals have billed amounts of $1,000 each, but 60 of them have billed amounts of $10,000 each, CMS will settle 400 appeals that have the billed amounts of $1,000 each. The 60 appeals that have billed amounts of $10,000 each are ineligible for settlement as part of the LVA.

Morris Plater: Question 11. Does the fewer-than-500-appeals limitation apply to the appeals pending at OMHA and the Council at the Departmental Appeals Board collectively, or is it—the fewer-than-500-appeals limitation—applicable at each level?

Ronke Fabayo: This option is available for appellants with fewer than 500 appeals pending collectively at OMHA and the Council. In other words, if an appellant has appeals pending at both OMHA and the Council, the total number of appeals pending in total must be fewer than 500 appeals.

Morris Plater: Question 12. Must an appellant settle all eligible appeals?

Ronke Fabayo: Yes. For the appellant to receive any payment as part of this settlement, the appellant must settle all eligible appeals for each NPI submitted. The appellant may not choose to settle some eligible appeals and continue to appeal others.

Morris Plater: Question 13. Is there a restriction or limitation for participation based on dates of service?

Ronke Fabayo: There is no specific restriction based on dates of service.

Morris Plater: Question 14. If at some point in the process an appeal was determined to be ineligible for settlement, will I be allowed to continue the normal appeal – appeals process for that appeal?

Ronke Fabayo: Yes, you will be able to continue the normal appeals process for appeals that are found to be ineligible.
Morris Plater: Question 15. Can appellants who otherwise meet the eligibility criteria be excluded from settlement by CMS?

Ronke Fabayo: Yes, certain appellants may be excluded from this process based on False Claims Act litigation or investigation or other program integrity concerns, including pending civil, criminal, or administrative investigation. Appellants who have filed for bankruptcy or who expect to file for bankruptcy are also excluded from settlement. An appellant that is – excuse me – an appellant that is excluded from settlement will receive a letter from CMS notifying that appellant that it may not participate.

Morris Plater: Question 16. Who is authorized to be the point of contact on the EOI?

Ronke Fabayo: The appellant may identify whomever it prefers to be the appellant point of contact.

Morris Plater: Question 17. How will the settlement affect the claim's history?

Ronke Fabayo: The claim history will remain as denied, and no claim level adjustments will be taken or will be made – will take place, rather. A Medicare Summary Notice (MSN) will not be sent to the beneficiary.

Morris Plater: Question 18. Is the 62-percent settlement percentage calculated per associated claim? Or does the 62 percent apply to the sum of all the claims submitted?

Ronke Fabayo: The 62 percent is calculated per associated claim and then added together to be issued to the appellant in one lump sum payment. This payment could be netted against outstanding overpayment, which could result in no payment to the appellant.

Morris Plater: Question 19. Do appellants still have appeal rights if they disagree with CMS's assessment?

Ronke Fabayo: Appellants may abandon the settlement process at any time prior to submitting the signed Administrative Agreement. Once the signed Agreement is returned to CMS, appellants will no longer have the opportunity to appeal or otherwise dispute the inclusion of – the inclusion or exclusion of appeals and their associated claims. Appellants who abandon the process at any time prior to submitting the signed Administrative Agreement will remain in the traditional appeals process.

Morris Plater: Question 20. Should the appeals Spreadsheet be sent securely, since it includes protected health information?

Ronke Fabayo: Yes, CMS will send the appellant an encrypted Spreadsheet. In turn, the appellant will send CMS an encrypted response.

Morris Plater: Question 21. I understand that the settlement is 62 percent of the net approved amount. What happens if I do not agree with the MAC's calculations of the net approved amount?

Ronke Fabayo: If you believe that there were – there was a miscalculation on a specific claim associated with the settled appeal, contact the MAC regarding the calculation. MACs can review the accuracy of the calculations.
Morris Plater: Question 22. If I choose the settlement option, will I need to submit withdrawals for the pending appeals included in the settlement?

Ronke Fabayo: If an appellant executes the Settlement Agreement with CMS, the appellant agrees that all appeals included in the settlement will be dismissed. The appellant is not required to submit withdrawals for the appeals. OMHA and the Council will dismiss any applicable cases based on the finalized Settlement Agreement after notification from CMS. The finalized Settlement Agreement serves as both the appellant's withdrawal of the eligible appeals and as the dismissal of appeals by OMHA or the Council.

Morris Plater: Question 23. My Administrative Law Judge hearing is scheduled to occur during the eligibility timeframe for this settlement option, and I want to pursue the settlement option. What should I do?

Ronke Fabayo: Each appellant may determine how it wishes to handle its scheduled hearing on an appeal-by-appeal basis. If you choose to pursue the settlement option and wish to postpone a scheduled hearing, please contact the ALJ team assigned to hear your appeal and request a continuance in writing. State that you are requesting a continuance while you pursue a resolution via CMS's low volume appeals settlement option and send copies of that correspondence to all other parties to the appeal. Contact information for the ALJ team assigned to your appeal is available on the Notice of Hearing (see the top right-hand corner of that first page) or through the ALJ Appeal Status Information System found on the OMHA website using either the Qualified Independent Contractor (QIC) or ALJ appeal number.

If you choose to pursue the settlement option and wish to attend your hearing as scheduled, you may do so until CMS receives your signed Administrative Agreement. Once CMS receives an appellant's signed Administrative Agreement, that appellant's eligible active appeals will be moved to a "pended" status in the appeals management system shared by CMS and OMHA. When an appeal is moved to the "pended" status, the ALJ team will not be able to process the appeal further and no hearing will be conducted.

Morris Plater: Question 24. What is the appellant's refund responsibility related to the beneficiary's coinsurance and deductible?

Ronke Fabayo: The appellant's refund responsibility is as follows:

If the beneficiary coinsurance has been collected at the time CMS signs the Administrative Agreement, no refund is required.

If the beneficiary coinsurance has not been collected at the time CMS signs the Administrative Agreement, the appellant must cease collections.

If a beneficiary repayment plan has been executed at the time CMS signs the Administrative Agreement, the appellant may continue to collect the coinsurance in accordance with the payment plan.

Morris Plater: Question 25. Will the Medicare Cost Report be impacted by the Administrative Agreement?

Ronke Fabayo: No, the Medicare Cost Report will not be impacted by the Administrative Agreement. The Administrative Agreement results in one lump sum payment, which is 62 percent of the allowed amount to the appellant. Claims and the cost report will not be adjusted for any reason. This includes reimbursement for DSH payments, indirect medical education, GME, and any other payments made on the cost report.

Morris Plater: Question 26. Are there limitations on what type of providers/suppliers may participate in this option? Specifically, would a rehab agency be eligible to participate if all other criteria were met?

Ronke Fabayo: Yes, a rehab agency would be eligible to participate if all appellant and appeal eligibility criteria are met. Certain appellants may be excluded from this settlement opportunity due to False Claims Act litigation or investigation or other program integrity concerns, including pending civil, criminal, or administrative investigation. Appellants that have filed for bankruptcy or expect to file for bankruptcy are also ineligible for this settlement.

Morris Plater: Question 27. Are there specific denial reasons related to claim appeals that are not eligible for LVA?

Ronke Fabayo: There are no specific denial reason restrictions for participation in LVA. As long as all the claims on the appeal are fully denied and all of the eligibility criteria are met, appeals for various denial reasons are eligible.

Morris Plater: Question 28. What if the denial was related to a DRG review and the review resulted in a change in the DRG with a lower payment and the provider received the lower payment due to the change in the DRG? Will the 62 percent of the net approved amount be based on the original DRG payment on the originally submitted claim?

Ronke Fabayo: This appeal would not be eligible for LVA because DRG review claims are not in a fully denied status and all claims associated with an appeal must be in a fully denied status to be eligible for LVA. Please note this response is the same for appeals that contain down-coded claims even if it – even if not DRG related. In order for the appeal to be eligible for LVA, the claims in the appeal must be in a fully denied status.

Morris Plater: Question 29. What if the claims under my appeal have multiple claim lines and one of the claim line items is denied? Is that appeal eligible for this settlement option?

Ronke Fabayo: No, all of the claim item – claim line items of an appeal need to be in a fully denied status to be eligible for this settlement option.

This now concludes our frequently asked questions portion of the presentation. Thank you, Morris, for your help. Should you have any further questions that were not addressed today, please send them to us at medicaresettlementfaqs—with a plural—so medicaresettlementfaqs (all one word) @cms.hhs.gov.

Helpful Resources and Information

Moving to slide 18, we have discussed a few acronyms and wanted to make sure that we're all on the same page about the meaning of the acronyms. In this presentation, we used LVA. LVA stands for low volume appeals settlement. OMHA stands for Office of Medicare Hearings and Appeals. Council stands for Medicare Appeals Council at the Departmental Appeals Board. NPI stands for National Provider Identifier. EOI stands for Expression of Interest. EDR stands for Eligibility Determination Request. MAC stands for Medicare Administrative Contractor.

Moving to slide 19, we wanted to make sure that you're aware of the resources available to you should you have any further questions after this settlement – after this provider call. The first resource is the LVA website. The website address, again, is go.cms.gov/lva. The website has a ton of helpful information about this settlement. Specifically, you will find the Expression of Interest, which, as Casey mentioned, needs to be completed in order to initiate the settlement process. You will also find a process document, as well as a process flow diagram. These documents provide step-by-step guide – a step-by-step guide of the process and what to expect throughout the process. You will also find a more detailed FAQ document, which we will update regularly to provide responses to any new questions we receive. Finally, you will find the Eligibility Determination Request document, which, as Casey mentioned, can be used to dispute the appellant or appeal eligibility.

The second resource if you have any questions is to send us an email. We have two different email addresses. The first one was the one that I gave out a few seconds ago, medicaresettlementfaqs@cms.hhs.gov. This email address can be used to ask us any general questions about the process. The second email address that we have is cmsmedicareappeals—plural appeals—settlement, so, again, it's cmsmedicareappealssettlement@cms.hhs.gov.

****Post-Call Clarification****
The correct email address is medicareappealssettlement@cms.hhs.gov. "The second email address that we have is medicareappeals—plural appeals—settlement, so, again, it's medicareappealssettlement@cms.hhs.gov."

This email address should be used to discuss your questions related to your EOI or your submission once you've entered the settlement process.

Finally, if you or your current appeals do not meet the eligibility criteria we discussed during the call, there is another settlement option we would like to make you aware of. This option is OMHA Settlement Facilitation Conference, or SCF. SCF is an alternative dispute resolution process – excuse me – at OMHA and gives certain appellant providers and suppliers an opportunity to resolve their eligible Part A or Part B appeals. It allows the appellant and CMS to discuss the potential of a mutually agreeable resolution for claims appealed to the third level of the Medicare appeals process. For information on this process, please visit OMHA's website or the link provided at the bottom of slide 19.

Thank you very much. I will now turn it over to Hazeline.

Additional Information

Hazeline Roulac: Thank you, Ronke. That ends our presentation for today.

If you did – if we did not address your question, you can email it to the address listed on slide 19. For information on evaluating today's call, see slide 20. We hope you will take a few moments to evaluate your experience with today's call. If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the CMS website in approximately 2 weeks.

Again, my name is Hazeline Roulac. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network call on Low Volume Appeals Settlement Option. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.