OMHA Settlement Conference Facilitation Pilot Program: Strategic Considerations for Home Health Agencies

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Home Health Agency Audit Risk Areas

- Face-to-face encounter documentation
  - Brief Narrative (Certification periods before January 1, 2015)
  - Physician medical record documentation (Certification periods on and after January 1, 2015)
- Homebound status
- Skilled therapy services
- Skilled nursing services

Home Health Agency Audit Risk Areas: RAC Approved Issues

- No skilled services: To qualify for the home health benefit, a patient must need a skilled service. When a skilled service is needed, dependent services such as home health aide may also be covered. Dependent services are not covered for a patient who no longer needs a skilled service.
  - States impacted: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT

Home Health Agency: History of Brief Narrative

- **Nat'l Ass'n for Home Care & Hospice, Inc. v. Burwell**, 77 F. Supp. 3d 103 (D.D.C. 2015)
  - NAHC challenged HHS's authority to enforce the brief narrative requirement
  - Court upheld HHS's authority to require the brief narrative, however:
    - Does not allow for denials simply because of poor word choice, grammar, or sentence structure
    - Would be invalid if it permitted a reviewer to deny a claim on the basis of inadequate documentation because the reviewer disagreed with the physician's clinical findings
- HHS largely eliminated the narrative requirement for certification periods beginning on or after January 1, 2015
- Voluminous brief narrative technical denials with certification periods between April 1, 2011 – January 1, 2015
- Judicial gloss may make these cases good candidates for SCF

Medicare Appeals Process

- *Rebuttal and Discussion Period*
- Redetermination
  - Appeal deadline: 120 days (30 days to avoid recoupment)
- Reconsideration
  - Appeal deadline: 180 days (60 days to avoid recoupment)
  - Full and early presentation of evidence requirement
- Administrative Law Judge Hearing
  - Appeal deadline: 60 days
  - CMS will recoup any alleged overpayment during this and following stages of appeal
- Medicare Appeals Council (MAC)
  - Appeal deadline: 60 days
- Federal District Court
  - Appeal deadline: 60 days

Medicare Appeals Process

ALJ Request Requirements (42 C.F.R. 405.1014)

1. Beneficiary name, address and HICN
2. Name and address of appellant (if not beneficiary)
3. Name and address of designated representatives (if appropriate)
4. Medicare Appeal Number (assigned by QIC)
5. Date(s) of service
6. Reasons for disagreement with QIC's decision
7. Statement of any additional evidence to be submitted and the date it will be submitted

Medicare Appeals Process

- **Best practices for ALJ appeals**
  - Prominently list Medicare Appeal Number on your request
  - Ensure beneficiary information matches Medicare Appeal Number
  - List beneficiary's full HICN
  - Include first page of QIC decision or prominently list full name of QIC
  - Document Proof of Service to other parties
  - Do not submit courtesy copy to QIC
  - Submit only one request per Medicare Appeal Number
  - Mail request via tracked mail to OMHA Central Operations
  - Do not submitted evidence already submitted to lower level
  - Do not attach evidentiary submissions or submit additional filings to OMHA Central Operations
  - Wait until an ALJ is assigned and submit directly to ALJ

- **OMHA Case Processing Manual**
  - Important resource for parties appealing to the ALJ level
  - http://www.hhs.gov/omha/OMHA_Case_Processing_Manual/index.html

Contractor Participation in ALJ Hearing

- The nature of the contractor's involvement in the hearing often is impacted by how they choose to participate. (42 CFR § 405.1010)
  - Two Options for Participation:
    - Party
    - Non-Party Participant (more common)
  - As non-party participants contractors **may not**:
    - Call witnesses
    - Cross-examine a provider's witnesses
    - Be called by the provider as a witness
  - As non-party participants contractors **may**:
    - File position papers
    - Provide testimony to clarify factual or policy issues of the case
- **Notice Requirements for Contractors**: 10 days after receiving the notice of hearing (42 CFR § 405.1010(b))

Audit Defense Strategies

- Arguing the merits
  - Merit-based arguments include:
    - Medical necessity of the services provided
    - Face-to-face documentation met regulatory and sub-regulatory requirements
    - National Association of Home Care & Hospice v. Burwell, Case No. 14-cv-00950 (CRC) (November 3, 2015)
  - To effectively argue the merits of a claim:
    - Draft a position paper laying out the proper coverage criteria
      - CMS program manuals
      - National coverage determinations (NCDs)
      - Local coverage determinations (LCDs)
      - MAC educational materials (non-binding)
    - Summarize submitted medical records and documentation
- Use of experts
  - Medical experts
  - Statisticians

Audit Defense Strategies

- Waiver of liability
  - Under waiver of liability, even if a service is determined not to be reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

Audit Defense Strategies

- Caring Hearts Personal Home Services, Inc. v. Burwell, No. 14-3243 (D.C. No. 2:12-CV-02700-CM-KMH) (D. Kan.) May 31, 2016
  - Federal appeals court vacated lower court's decision to uphold CMS' denial on the basis that CMS applied improper standards:
    - CMS applied homebound standard that was not in effect at the time the services were rendered;
      - "….The trouble is, in reaching its conclusions CMS applied the wrong law…Regulations that Caring Hearts couldn't have known about at the time it provided services….it's a case about an agency struggling to keep up with the furious pace of its own rulemaking."
    - CMS cited to regulatory language in support of the denial of physical therapy and skilled nursing services that were not in effect at the time the services were rendered;
      - CMS also cited to the wrong regulation - emphasizing to the court that CMS is unclear of its own laws.

Audit Defense Strategies

- Caring Hearts Personal Home Services, Inc. v. Burwell, No. 14-3243 (D.C. No. 2:12-CV-02700-CM-KMH) (D. Kan.) May 31, 2016
  - "This case has taken us to a strange world where the government itself – the very "expert" agency responsible for promulgating the "law" no less – seems unable to keep pace with its own frenetic lawmaking. A world Madison worried about long ago, a world in which the laws are "so voluminous they cannot be read" and constitutional norms of due process, fair notice, and even the separation of powers seem very much at stake."

Audit Defense Strategies

- Provider without fault
  - Once an overpayment is identified, payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services.
  - "Fault" for purposes of the provider without fault provision:
    - (a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or
    - (b) Failure to furnish information which he knew or should have known to be material; or
    - (c) With respect to the overpaid individual only, acceptance of a payment, which he knew or could have been expected to know, was incorrect.
  - Incorporation of Provider without Fault for Face-to-Face Denials
    - Any favorable claims with substantially similar face-to-face encounter documentation?

ALJ APPEALS

- As of February 2015, ALJ appeals had been pending for an average of 572 days
- Office of Medicare Hearings and Appeals (OMHA) receives as many or more appeals every two months than it can process in a full year
- Suggestion that at current rates, some already-filed claims could take a decade or more to resolve
- American Hospital Association, et. al. v. Burwell (No. 1:14-cv-00851) (Feb. 9, 2016)
- OMHA workload – appeal receipts
  - 2015 – 240,371
  - 2014 – 474,063
  - 2013 – 384,151
  - 2009 – 40,831
- Current backlog is approximately 770,000 cases pending.

Judicial Relief re: Appeals Backlog

American Hospital Association, et. al. v. Burwell (No. 1:14-cv-00851) (Feb. 9, 2016)

- AHA sought a writ of mandamus compelling HHS to act within the specified appeal time frames
  - "[ALJs] shall conduct and conclude a hearing . . . and render a decision . . . by not later than the 90-day period beginning on the date a request for hearing has been timely filed." 42 U.S.C. § 1395ff(d)(1)(A)
- District court concluded mandamus relief was unwarranted
- Reversed and remanded by United States Court of Appeals for the District of Columbia Circuit
  - "[C]ommon sense suggests that lengthy payment delays will affect hospitals' willingness and ability to provide care."
  - Statute imposes a clear duty on HHS to comply with the statutory deadlines, statute gives AHA a corresponding right to demand compliance with the deadlines, and escalation is an inadequate alternative remedy in the circumstances of this case
  - "In the end, although courts must respect the political branches and hesitate to intrude on their resolution of conflicting priorities, our ultimate obligation is to enforce the law as Congress has written it. Given this, and given the unique circumstances of this case, the clarity of the statutory duty likely will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle."

Legislative Relief re: Appeals Backlog

- Senate Bill 2368, Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM)
- Introduced in Senate on December 8, 2015
- Purpose: "Increase coordination and oversight of Medicare claims review contractors, implement new strategies to address the growing number of review contractor determination appeals, reduce review burdens on providers, and give review contractors the tools necessary to better protect the Medicare Trust Fund." Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 Committee Report
- Appropriates an additional $127 million per year from the Medicare Trust Funds (OMHA to receive $125 million and DAB to receive $2 million)

Legislative Relief re: Appeals Backlog

- **AFIRM's reforms to Medicare audit process:**
  - Establish CMS Ombudsman for Medicare reviews and appeals
    - Identify, investigate and assist resolving complaints and inquiries regarding Medicare review or the Medicare appeals process
    - Recommend improvements to Secretary of U.S. Department of Health and Human Services (HHS)
  - Establish and implement (by 1/1/17) a system to track a provider's denial rate as a percentage of the claims audited and final determination of appeals by type of issue
    - Suppliers or providers with a low error rate from RAC and MAC audits would be temporarily exempted from RAC and MAC post-payment audits
  - Tie a review entity's accuracy rate with Medicare law, policies and program instruction to its ability to request medical records
    - Example: review entities with a 95% accuracy rate or less may be limited in their ability to request medical records
  - Require review contractors to have audits conducted or approved by medical doctors knowledgeable of relevant Medicare laws, policies and program instruction

Legislative Relief re: Appeals Backlog

- **AFIRM's reforms to Medicare appeals process:**
  - Implement Medicare magistrates
  - Permit decisions on the record without a hearing if no material issues of fact in dispute and if ALJ or magistrate determine there exists "binding authority that controls the decision in the matter under review."
    - Favorable *or* unfavorable determinations
  - Require OMHA to initiate ADR processes
  - Permit reviewers at *any* level of appeal to consolidate more than one pending request for appeal into a single appeal in certain situations
  - Require the QIC, magistrate, ALJ or DAB to remand an appeal to the MAC for redetermination if the appellant submits new evidence at a subsequent level of appeal
    - Exceptions: reviewer inadvertently omits evidence from the administrative record at lower level; new findings issued on appeal; other circumstances as determined by the Secretary of HHS
    - What about preventing recoupment and subsequent remand?

Don't Wait, Facilitate: OMHA Settlement Conference Facilitation

Settlement Conference Facilitation (SCF) Pilot

- Designed to bring CMS and Appellant together to discuss the potential of a mutually agreeable resolution for claims appealed to the ALJ
- If a settlement cannot be reached, claims return to ALJ appeal level
- **Phase I (Implemented in June 2014)**
  - Medicare Part B claims appeals
  - For ALJ hearing requests filed in 2013.
  - Resolved over 2,600 unassigned Part B ALJ Appeals
    - Equivalent of more than two ALJ teams in one year
- **SCF Expansion**
  - Phase II – October 2015 (Part B claims appeals expanded)
  - Phase III – February 2016 (Part A claims appeals)

SCF Expansion: Phase III

Phase III Eligibility Criteria

- All Part A provider types are eligible
- The request for hearing must not be scheduled for ALJ hearing (no Notice of Hearing)
- The request for hearing must have been filed on or before December 31, 2015
- Part A QIC reconsideration (not dismissals)
- The claims at issue are covered under Medicare Part A law and policy
- Appellant must be a provider = NPI
- No beneficiary liability after initial determination or participation at QIC reconsideration
- Jurisdictional requirements for ALJ hearing met (timely, amount in controversy)
- At least 50 claims must be at issue and at least $20,000 must be in controversy
- Each individual claim must be $100,000 or less
  - For the purposes of an extrapolated statistical sample, the extrapolated amount must be $100,000 or less
- There cannot be an outstanding request for OMHA statistical sampling for the same claims

SCF Expansion: Phase III

Phase III Eligibility Criteria (cont.)

- The request must include all of the appellant's pending appeals for the same item or service at issue that meet the SCF criteria
- Appellants may not request SCF for some but not all of the items or services included in a single appeal
  - For example, if an individual appeal has at issue 10 hospice claims and 10 home health claims, an appellant may not request that the hospice claims go to SCF, but the home health claims go to hearing
- The appellant has not filed for bankruptcy and/or does not expect to file for bankruptcy in the future

SCF Process

- **Step 1:** Provider completes Medicare Part A Expression of Interest requesting that OMHA run a preliminary report of its pending ALJ appeals and initiate the SCF process
  - Alternatively, OMHA may initiate a preliminary report on its own initiative or at the request of CMS

SCF Expression of Interest – Terms and Tips

- OMHA will not accept electronic signatures
- Email the completed Expression of Interest in PDF format to OMHA.SCF@hhs.gov
- Providers interested in facilitation for Part A appeals must complete a Part A Expression of Interest for the Part A appeals.
- Separate providers that are related business entities can combine multiple provider numbers into one Expression of Interest
- Failure to protect beneficiaries' private data will result in rejection of appeals from SCF process
  - Beneficiary first or last name or initials, addresses, truncated health insurance claim numbers

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

SETTLEMENT CONFERENCE FACILITATION (SCF) EXPRESSION OF INTEREST

Medicare Part A Administrative Law Judge Appeals

To formally request OMHA Settlement Conference Facilitation, you must first receive an OMHA *Settlement Conference Facilitation Preliminary Notice*. If you have not received this notice, and wish to initiate the process yourself, you must complete this *Settlement Conference Facilitation Expression of Interest* form to request that OMHA produce the Preliminary Notice.

You may e-mail this completed form in PDF format to OMHA.SCF@hhs.gov. OMHA cannot accept electronic signatures at this time. Please scan your Expression of Interest form, with original signature, into PDF format and then send it as an attachment.

If you are a provider or supplier who is interested in Settlement Conference Facilitation (SCF) for Medicare Part A and Medicare Part B appeals, please complete this form and the Part B *Expression of Interest* form and submit both forms together in one email.

You must not email any beneficiary personally identifiable information including beneficiary first or last names, beneficiary names represented by initials, beneficiary addresses, or truncated health insurance claim numbers (HICN). You must only provide the information requested in this form. Failure to protect beneficiaries' private data will result in rejection of your appeals from the SCF process.

For more information on the OMHA SCF process, please visit the OMHA website at www.hhs.gov/omha or contact us at OMHA.SCF@hhs.gov.

Appellant Name (the provider or supplier that appealed the QIC reconsideration):

Please note, if you are a Medicare beneficiary or a Medicaid State Agency, your claim appeals are not currently eligible for the OMHA Settlement Conference Facilitation process.

Appellant point of contact (not necessary if represented)	Representative name (if applicable) (must be an individual)
E-mail Address:	E-mail Address:
Point of Contact Title (not necessary if represented)	Representative firm or business (if applicable)
Address	Address
City State Zip Code	City State Zip Code
Phone Number (extension #, if any) / Fax Number	Phone Number (extension #, if any) / Fax Number

Medicare Part A National Provider Identifier (NPI) and corresponding Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN). If claims were submitted under multiple identification numbers, list all of the identification numbers at issue.

Please **do not** handwrite NPI, PTAN, or CCN numbers. If you need additional space, please attach in a separate document:

NPI	PTAN or CCN

Indicate whether the appealed claims pending are pre-payment denials, post-payment denials, or both:

☐ Pre-Payment ☐ Post-Payment

Has the appellant filed for bankruptcy and/or is expected to file for bankruptcy in the future? If yes, the appellant is not eligible for SCF.

☐ YES ☐ NO

I am requesting that OMHA initiate the SCF process for my appeals that are pending an Administrative Law Judge hearing. I understand that OMHA will review the appeals that I have pending and determine, to the best of its ability, which appeals would be eligible for SCF, if any.

I understand that this Expression of Interest serves only to initiate the settlement conference process. This Expression of Interest is not my formal request for SCF. I further understand that I cannot formally request SCF until I receive an *SCF Preliminary Notification* from OMHA. I understand that the Centers for Medicare & Medicaid Services (CMS) are not obligated to enter into a settlement agreement with me. I also understand that any party may respectfully decline participation in the SCF process at any time.

I am authorized to initiate the SCF process on behalf of the appellant identified above. I attest that the information provided in this form is true and correct to the best of my knowledge.

Appellant Signature	Appellant Printed Name	Date

SCF Process (cont.)

- **Step 2:** OMHA forwards the preliminary report to CMS
  - No timeline on OMHA to forward to CMS;
  - CMS has 15 days to determine whether it will participate
- **Step 3:** If CMS indicates it will participate, OMHA completes an SCF spreadsheet of all eligible appeals
  - OMHA will notify ALJ teams at this time to stop processing the claims
- **Step 4:** OMHA sends provider a SCF Preliminary Notification and the SCF spreadsheet
- **Step 5:** Provider has 15 days from receipt to file a complete SCF Request package:
  - (1) Request for SCF form, (2) Agreement of Participation form, and (3) SCF Request spreadsheet (with all appellant columns completed)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

REQUEST FOR SETTLEMENT CONFERENCE FACILITATION

Medicare Part A & Part B Administrative Law Judge Appeals

To request an OMHA settlement conference, you must first receive an OMHA *Settlement Conference Facilitation (SCF) Preliminary Notice*. After receiving your preliminary notice, you must submit this form, the *SCF Agreement of Participation*, and a complete *SCF Request Spreadsheet* to OMHA.

Electronic submission of all materials on a flash drive or CD is mandatory. OMHA cannot accept electronic signatures at this time. Please scan your *Request for SCF* and *SCF Agreement of Participation*, with original signatures, into PDF format. **Your *SCF Request Spreadsheet* must be sent in Excel format (.xlsx).**

For more information on the OMHA SCF process, please visit the OMHA website at www.hhs.gov/omha or contact us at OMHA.SCF@hhs.gov.

Please send your complete request package to the following address *(US Postal Service, non-signature delivery strongly recommended). Please note this is a new address*:

Office of Medicare Hearings and Appeals
Settlement Conference Facilitation Program
5201 Leesburg Pike
Suite 1300
Falls Church, VA 22041

Appellant Name (the provider or supplier that appealed the QIC reconsideration):

Please note, if you are a Medicare beneficiary or a Medicaid State Agency, your claim appeals are not currently eligible for the OMHA SCF process.

Appellant point of contact (not necessary if represented)		Representative name (if applicable) (must be an individual)	
Point of Contact Title (not necessary if represented)		Representative firm or business (if applicable)	
E-mail Address:		E-mail Address:	
Address		Address	
City State Zip Code		City State Zip Code	
Phone Number (extension #, if any)	Fax Number	Phone Number (extension #, if any)	Fax Number

National Provider Identifier (NPI) and corresponding Provider Transaction Access Number (PTAN) or CMS Certification Number (CCN). If claims were submitted under multiple identification numbers, list all of the identification numbers at issue.

Please **do not** handwrite NPI/PTAN or CCN numbers. If you need additional space, please attach in a separate document:

NPI	PTAN or CCN

Indicate whether claims are pre-payment and/or post-payment denials:

☐ Pre-Payment Denial ☐ Post-Payment Denial

Are all claims covered under Medicare Part A and/or Medicare Part B?

☐ Part A ☐ Part B

Are you only appealing QIC reconsideration decisions (that is, none of the claims were dismissed by the QIC)?	☐ Yes	☐ No
Were all of the requests for ALJ hearing timely filed (that is, they were filed with OMHA within 60 days of your receiving the QIC reconsideration notice)?	☐ Yes	☐ No
Is the amount in controversy (AIC) met for each claim that is being appealed, or if it was not met for a claim, was a request for aggregation submitted with the request for hearing for claims that did not meet the amount in controversy requirement? For calendar year (CY) 2013 and CY 2014, the AIC was $140. For CY 2015, the AIC is $150.	☐ Yes	☐ No
Are all of the requests for ALJ hearing unscheduled for an ALJ hearing (that is, you have not received a Notice of Hearing)?	☐ Yes	☐ No
Is the amount of each claim $100,000 or less? (For the purposes of an extrapolated statistical sample, the extrapolated amount must be $100,000 or less.)	☐ Yes	☐ No
Have you received an OMHA *SCF Preliminary Notification*?	☐ Yes	☐ No

NOTE: If any of the above responses are marked No, please contact OMHA at the phone number listed on your SCF Preliminary Notification or at the email address above. If a request for SCF is submitted and includes appealed decisions or claims that are not eligible for the process, the request for SCF will be delayed and the ineligible appeals and associated claims will not be considered.

Was the beneficiary found liable for the denied items or services at the redetermination or reconsideration level for any of the appealed claims?	☐ Yes	☐ No
Did the beneficiary participate at the QIC reconsideration level for any of the appealed claims (for example, file a request for reconsideration or offer the QIC written testimony)?	☐ Yes	☐ No

Is there an outstanding request for OMHA statistical sampling for the same claims in this request?	☐ Yes	☐ No
Has the appellant filed for bankruptcy and/or is expected to file for bankruptcy in the future?	☐ Yes	☐ No
Do any of the claim(s) involve services, drugs, or biologicals billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes (for example, CPT Code 38999 Unlisted procedure, hemic or lymphatic system; HCPCS Code J3490 Unclassified drugs)? Equipment and other items billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes are eligible for SCF.	☐ Yes	☐ No
Were any of the claims eligible for the CMS Part A Hospital Appeals Settlement option?	☐ Yes	☐ No

NOTE: If any of the above responses are marked "Yes," please contact OMHA at the phone listed on your SCF Preliminary Notification or at the email address above. If a request for SCF is submitted and includes appealed decisions or claims that are not eligible for the process, the ineligible appeals and associated claims will not be considered for settlement or the entire SCF request may be rejected.

You must also complete the SCF Agreement of Participation and the SCF Request Spreadsheet. Electronic submission of all documents on a CD or flash drive is mandatory. You may not submit your SCF Request Spreadsheet as a PDF document.

Please provide a narrative explanation of why the claims included in this request were denied. You may attach your narrative in a separate document if it will not fit this space. Please be as specific as possible.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

SETTLEMENT CONFERENCE FACILITATION
AGREEMENT OF PARTICIPATION

To request an OMHA Settlement Facilitation Conference, please submit this form, your request, and the Settlement Conference Facilitation Request Spreadsheet. Electronic submission of all materials is mandatory (Note: Electronic signatures are not acceptable. Please scan your Agreement of Participation, with original signatures, into PDF format and submit on a CD or flash drive).

For more information on the OMHA Settlement Conference Facilitation process, please visit the OMHA website at www.hhs.gov/omha or contact us at OMHA.SCF@hhs.gov.

Please send your complete request package to the following address:

U.S. Department of Health and Human Services
Office of Medicare Hearings and Appeals
Settlement Conference Facilitation Program
5201 Leesburg Pike
Suite 1300
Falls Church, VA 22041

Settlement Conference Terms

Instructions: Appellants please complete the section below. Only original signatures will be accepted.

I understand and agree to the following:

- An individual authorized to sign a binding agreement on behalf of the appellant(s) must be present at the Settlement Conference Facilitation session and the request for Settlement Conference Facilitation will be closed if an authorized individual does not appear at the conference;
- The appellant has not filed for bankruptcy and/or is not expected to file for bankruptcy in the future;
- I understand that the settlement agreement may be void if the appellant has filed for bankruptcy or is expected to file for bankruptcy in the near future;
- Regardless of whether a settlement agreement is reached, I will not seek fees under the Equal Access to Justice Act (EAJA);
- I understand the Centers for Medicare and Medicaid Services (CMS) will not pay fees under EAJA;
- I agree to limit discussion of the claims in my Settlement Conference Facilitation Spreadsheet to the Settlement Conference Facilitation process. I verify that the claims on the spreadsheet meet the Settlement Conference eligibility requirements;
- I agree that I will not separately contact any individual within any division of CMS or its contractors regarding such claims throughout the duration of the Settlement Conference Facilitation process.
- If a settlement agreement is reached, it will be binding and not appealable;
- If a settlement agreement is reached, by signing the agreement, I will be agreeing to withdraw all of the requests for an ALJ hearing and not pursue further appeals for the claims covered by the settlement agreement; and
- If a settlement is reached, the settlement does not exempt the claims from review for potential fraud and any civil or criminal actions that commence as a result of such a review.
- I understand that these terms apply to all of the providers/suppliers listed in the ***Provider/Supplier Identification*** section of this Agreement of Participation.

Appellant Signature	Appellant Printed Name	Date

Last revised on November 17, 2015

Appointed Representative Acknowledgement

Instructions: Required completion if the appellant(s) representative will be signing the settlement agreement on behalf of the appellant(s). Only original signatures will be accepted.

The representative identified below is authorized by the appellant(s) listed in the ***Provider/Supplier Identification*** section to participate in the Settlement Conference Facilitation process and sign an agreement on behalf of the appellant(s). The representative has advised the appellant(s) that any agreement signed on the appellant(s) behalf will be binding on the appellant(s), and will include an agreement that the appellant(s) is withdrawing all of the requests for an ALJ hearing and not pursuing further appeals for the claims covered by the settlement agreement. The representative fulfilled his/her duty to advise the appellant(s) of the consequences of withdrawing a request for an ALJ hearing and the subsequent dismissal that will result from that action. Further, the representative agrees to limit discussion of the claims under review to the Settlement Conference Facilitation process. The representative will not separately contact any individual within any division of CMS or its contractors regarding such claims throughout the duration of the Settlement Conference Facilitation process.

Appellant Signature	Appellant Printed Name	Date
Representative Signature	Representative Printed Name	Date

Agreement to Participate in Settlement Conference Facilitation

Instructions: This section must be completed by every individual who will be in attendance at the settlement conference, regardless of actual participation in the settlement conference. Failure of every individual in attendance to complete this agreement will result in rejection of an appellant's request for settlement conference facilitation. If additional signature lines are needed, please download and complete the Addendum to Agreement to Participate in Settlement Conference Facilitation. Only original signatures will be accepted.

OMHA will forward this document to CMS for completion after it is signed by the appellant and submitted to OMHA with the complete request for settlement conference package.

As parties to this settlement conference, we voluntarily agree to mediation in the conference. We understand that mediation may be terminated at any time by either the parties or by the facilitators.

The facilitators have no authority to decide any case and are not acting as advocates or attorneys for any party. The parties have a right to representation during the settlement conference.

The confidentiality provisions of the Administrative Dispute Resolution Act (ADRA) apply to this settlement conference. The ADRA focuses primarily on protecting private communications between parties and the facilitator. Under ADRA, a party's oral communications to the facilitator during settlement conference mediation are protected. Written communications which a party prepares for mediation and gives only to the facilitator are also protected.

There are exceptions to the confidentiality provisions in ADRA. Statements made with all the other parties present or documents provided to other parties are not confidential. Also, in unusual circumstances, a court can order disclosure of information that would manifest injustice, help establish a violation of law, or prevent harm to public health and safety. Further, information concerning fraud and criminal activity or threats of imminent harm will not be considered confidential in this settlement conference.

No party shall be bound by anything said or done at the settlement conference, other than agreement to these terms and conditions, unless a written settlement is reached and executed by all necessary parties. By signature below, we acknowledge that we have read, understand, and agree to the terms and conditions stated herein.

Appellant or Representative Signature	Appellant or Representative Printed Name	Date
Appellant or Representative Signature	Appellant or Representative Printed Name	Date
Appellant or Representative Signature	Appellant or Representative Printed Name	Date
CMS Authorized Staff Signature	CMS Authorized Staff Printed Name	Date
CMS Authorized Staff Signature	CMS Authorized Staff Printed Name	Date
OMHA Facilitator Signature	OMHA Facilitator Printed Name	Date
OMHA Facilitator Signature	OMHA Facilitator Printed Name	Date

Settlement Conference Facilitation Agreement of Participation
Provider/Supplier Identification

Instructions: This section must identify every appellant whose claims will be addressed in the settlement conference. The terms listed in the preceding pages of the Agreement of Participation will apply to every appellant listed in this section. You may attach a separate list if you require more space.

For the purposes of Settlement Conference Facilitation, an appellant is defined as a Medicare provider or supplier that has been assigned a National Provider Identifier (NPI) number.

Appellant Name	NPI

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

Addendum to Agreement to Participate in Settlement Conference Facilitation

Use this form if you require additional signature lines for the Agreement to Participate. Only original signatures will be accepted.

Please send this completed form, your request, and other information to:

Office of Medicare Hearings and Appeals
Settlement Conference Facilitation Program
5201 Leesburg Pike
Suite 1300
Falls Church, VA 22041

This signature page is an addendum to the attached Agreement to Participate in Settlement Conference Facilitation. The undersigned agree to the terms stated in the attached Agreement.

Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
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Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date

Last revised on February 17, 2016

SCF Process (cont.)

SCF Settlement Agreement– Terms and Tips

- If settlement is reached, the settlement agreement must be signed the day of the settlement conference
- Terms of OMHA's Settlement Agreement are non-negotiable "in any form or fashion"
  - Read the Settlement Agreement: http://www.hhs.gov/omha/OMHA%20Settlement%20Conference%20Facilitation/SCF%20Part%20A%20Docs/scf_agreement_of_participation.pdf

SCF Phase III: Terms and Tips

- **SCF Settlement Agreement**
  - "No Admission – This agreement does not constitute an admission of fact or law by the Settlement Parties and shall in no way affect the rights, duties, or obligations the Settlement Parties may have with respect to other issues not covered by this agreement. This agreement does not constitute an admission of liability by Provider/Supplier or CMS." See OMHA SCF Settlement Agreement Template

  - No findings of fact or conclusions of law; claims remain denied
    - "Per CMS, the claims will remain denied in Medicare's systems" See OMHA SCF Pilot Fact Sheet

SCF Phase III: Terms and Tips

SCF Settlement Agreement– Terms and Tips (cont.)

- CMS will not perform claim-by-claim adjustments or reprocessing; payments will be made according to CMS' usual business practices (recoupment and/or offset)
- Settlement payments are a "percentage term"
  - For example, the parties could agree that CMS will pay 50% of the approved amount on the claims included in the SCF Request Spreadsheet
- Settlement of pre-payment claims:
  - % of the Medicare approved amount, less the applicable deductible and/or co-insurance, if any
  - If down-coding involved, the amount already paid by Medicare is subtracted from the above calculated amount
- Settlement of post-payment claims:
  - % by which CMS will reduce the overpayment(s) at issue
- CMS will issue payment (EFT or check) within 120 days from the *later* of:
  - The effective date of the Settlement Agreement; or
  - Agreement on the calculation of the Medicare net amount (after applicable reductions for pre-payment denials and/or the recalculation after the percentage reduction for post-payment denials)

SCF Phase III: Terms and Tips

SCF Settlement Agreement– Terms and Tips (cont.)

- Settlement Agreement releases CMS from full liability on the claims settled
- Settlement Agreement does not release provider from any claims arising under criminal law, False Claims Act, Civil Monetary Penalties Statute, common law fraud
- Settlement Agreement releases "any and all rights to further administrative review, judicial review or waiver of recovery" regarding the settled claims
- Provider agrees to withdrawal of pending ALJ hearing requests on the settled claims; ALJ dismissal orders for the withdrawn claims will be issued

SCF Process

SCF Spreadsheet

- Submit SCF Spreadsheet electronically in Excel format (.xlsx)
- Do not add columns, remove columns or edit column headers
- Failure to follow directions will result in rejection of SCF request package

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
1	**General Information:** Failure to follow all of the directions below will result in rejection of your SCF request package. **You must review the entirety of this spreadsheet and complete the columns highlighted in yellow.** Electronic submission of the SCF Spreadsheet via flash drive or CD is required. The spreadsheet must be submitted in Excel format (.xlsx). Do **not** submit a PDF document of the information requested in this spreadsheet. **Do not alter the format of this spreadsheet by adding columns, removing columns, or in any way editing column headers.** **NOTE: The second tab at the bottom of this document contains the Spreadsheet Key. If you have any questions regarding this spreadsheet, please contact OMHA at OMHA.SCF@hhs.gov.**																
2	Provider or Supplier Name:																
3	Type of Entity:									Appellant must complete the columns below.							
4	NPI Number	PTAN or CCN	Medicare Part	QIC Appeal Number	ALJ Appeal Number	Truncated HIC	# of Line Items Denied	Payer Claim Control Number	Billed Amount Denied	Post-Payment Claim? (Enter Y for "Yes", leave blank if "No")	Claim Adjustment Reason Code (CARC)	MIA/MIAO or RARC (if any	HCPCS/CPT Code	To/From Date of Service	QIC Decision Letter Mailed Date	OMHA Complete Request Received Date	
5																	
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	

SCF Process (cont.)

SCF Request Package – submission tips

- A complete SCF Request package contains:
  - (1) Request for SCF form, (2) Agreement of Participation form, and (3) SCF Request Spreadsheet (with all appellant columns completed)
- Electronic submission of all materials on a flash drive or CD is mandatory
- OMHA does not accept electronic signatures
- Submit Request for SCF form and Agreement of Participation form in PDF format (with original signatures)
- SCF Request Spreadsheet must be sent in Excel format (.xlsx)
- Mail the complete SCF Request Package via US Postal Service, non-signature to:

  U.S. Department of Health and Human Services
  Office of Medicare Hearings and Appeals
  Settlement Conference Facilitation Program
  5201 Leesburg Pike
  Suite 1300
  Falls Church, VA 22041

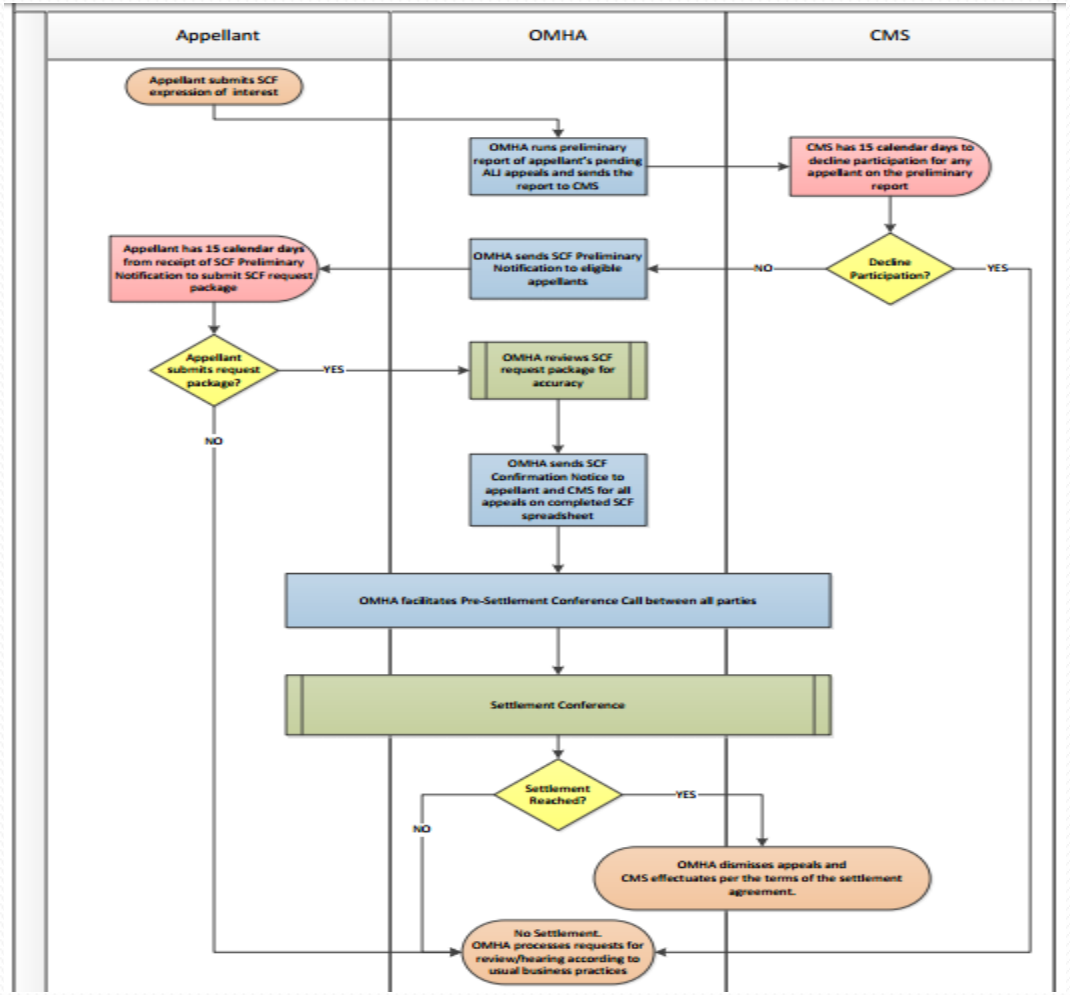
SCF Process (cont.)

- **Step 6:** OMHA issues confirmation notice to provider and CMS
- **Step 7:** Pre-settlement conference call with provider, CMS, and OMHA facilitators
  - Scheduled approximately four weeks after issuance of confirmation notice
- **Step 8:** Settlement conference conducted
  - Scheduled approximately three to four weeks after pre-settlement conference call

SCF: Best Practices

- Position Paper
  - Timing of submission (early submission for CMS decision makers)
  - Big-picture discussion
    - Trends
      - Patterns of initial denials/approvals
    - Appeal strategy (selective vs. 100%)
    - Previous approvals (at earlier levels of appeal and ALJ)
- Expert participation
  - Physician
  - Coder
  - Affidavits
- Sampling of claims
  - Who picks the sample
  - When are the claims sampled

SCF Process - Overview



Flowchart created by OMHA. Located at:
http://www.hhs.gov/omha/OMHA%20Settlement%20Conference%20Facilitation/SCF%20Part%20B%20Docs/scf_flowchart_b.pdf

SCF: Strategic Approach

Key Considerations

- One-day time period for settlement conference
- SCF process is voluntary for all parties until execution of settlement agreement
- Pre-settlement conference: SNFs/Hospitals with Part A and Part B claims – if submit part A and Part B EOI forms in one email, perhaps can resolve all claims at one mediation session
- Know your numbers
  - Dollar value at issue
    - SCF negotiations are strictly percentage-based
    - Pre-payment (denials) - % of Medicare approved amount less the applicable deductible and/or coinsurance
      - Pre-payment (down-coding) – the amount already paid by Medicare is subtracted from preceding calculated amount
    - Post-payment - % by which CMS will reduce the overpayment(s) at issue
  - Past ALJ success rate; projected future ALJ success rate
    - Favorable rulings on appeal range among ALJs from 18-85%
  - Costs of ALJ hearings
    - # of ALJ appeal requests
    - Internal resources (e.g., employee participation)
    - External resources (e.g., experts fees, attorney fees)
  - Time value of money
  - Certainty value of settlement
  - Interest on recouped claims ("935 interest")

SCF: Strategic Approach

Key Considerations

- 42 CFR 405.378(j) – When an overpayment is reversed in whole or in part by an ALJ, the provider is entitled to interest on the principal claim amount for the time period in which CMS had possession of the funds ("935 interest")
- SCF Standard Settlement Terms – CMS will not pay interest to Provider/Supplier pursuant to 42 CFR § 405.378(j) as there will be no Administrative Law Judge decision
- Provider waives ability to receive 935 interest on the recouped funds (post-payment audits)
- How much 935 interest is at issue for provider's claims?
- Interest paid by provider

SCF: Strategic Approach

"935 Interest" Example

- Value of SCF claims - $100,000
- Interest rate – 9.75% per annum on principal
- Total time CMS held recouped funds – 3 years
- "935 interest" at issue - $29,250
- Carefully consider "935 interest" when determining acceptable settlement amount

SCF: Strategic Approach

Key considerations

- How strong are your claims on the merits?
  - Strong cases = money left on the table?
  - Previous ALJ success rate for similar claims
- Dismissal of appeal, if settled
- Claims remain denied, if settled
  - Will not improve provider's error rate
  - Cannot seek further reimbursement from beneficiary
  - Secondary payor issue

SCF Strategy: Key Considerations (cont.)

- Waiver of liability
  - Section 1879(a) of the Social Security Act
  - Under waiver of liability, even if a service is determined not to be reasonable and necessary, payment may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, that payment would not be made.

- Provider without fault
  - Section 1870 of the Social Security Act
  - Once an overpayment is identified, payment will be made to a provider if the provider was without "fault" with regard to billing for and accepting payment for disputed services

Questions?

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