



## SETTLEMENT CONFERENCE FACILITATION

**Cherise Neville**  
Senior Attorney  
Office of Medicare Hearings and Appeals  
Program Evaluation and Policy Division



### What is Settlement Conference Facilitation?

- Settlement Conference Facilitation is an alternative dispute resolution process designed to bring the appellant and the Centers for Medicare & Medicaid Services (CMS) together to discuss the potential of a mutually agreeable resolution for claims appealed to the Administrative Law Judge hearing level.
- If a resolution is reached, the settlement conference facilitator drafts a settlement document to reflect the agreement. As part of the agreement, the request(s) for an Administrative Law Judge hearing for the claims covered by the settlement will be withdrawn and dismissed.

2



### Who is the Settlement Conference Facilitator?

Settlement conference facilitators are specially trained employees of the Office of Medicare Hearings and Appeals (OMHA), which is a component of the HHS Office of the Secretary, and is organizationally and functionally separate from CMS.

3



### What Does the Facilitator Do?

- Uses mediation principles to assist the appellant and CMS in working toward a mutually agreeable resolution.
- Does not make official determinations on the merits of the claims at issue and does not serve as a fact finder.
- May help the appellant and CMS see the relative strengths and weaknesses of their positions.

4



### Settlement Conference Facilitation: Eligibility Requirements



#### SCF Phase III: Eligibility Requirements

- The appellant must be a Medicare provider or supplier (for the purposes of this pilot, "appellant" is defined as a Medicare provider or supplier that has been assigned a National Provider Identifier (NPI) number);
  - All Part A provider types are eligible to request participation in the OMHA SCF Pilot, including acute care hospitals.
  - Claims that were eligible for the CMS Part A Hospital Appeals Settlement option are **ineligible** for the pilot regardless of actual provider participation in the settlement process with CMS.

5

6



### SCF Phase III: Eligibility Requirements

- A request for hearing must appeal a Medicare Part A Qualified Independent Contractor (QIC) reconsideration decision;
- The claims at issue are covered under Medicare Part A law and policy;
- The beneficiary must not have been found liable after the initial determination or participated in the QIC reconsideration;

7



### SCF Phase III: Eligibility Requirements

- The amount of each **individual** claim must be \$100,000 or less
  - For the purposes of an extrapolated statistical sample, the overpayment amount extrapolated from the universe of claims must be \$100,000 or less;
- At least 50 claims must be at issue and at least \$20,000 must be in controversy

8



### SCF Phase III: Eligibility Requirements

- The appellant has received a Settlement Conference Facilitation Preliminary Notification stating that the appellant may request SCF for the claims identified in the SCF spreadsheet.

9



### Requesting SCF

- Appellant submits an SCF *Expression of Interest* which requests that OMHA run a preliminary report of its pending appeals and initiate the SCF process.
- OMHA creates the preliminary report containing appellant claims which may be eligible for SCF and sends to CMS.
- CMS will then have the opportunity to indicate whether it will participate in SCF for the appellant based on the preliminary report.

10



### SCF Expansion: Requesting SCF

- Post CMS response, OMHA will complete an SCF Spreadsheet for the appellant(s) listed on the preliminary report. The SCF Spreadsheet will contain all OMHA appeals which OMHA believes may be eligible for SCF.

11



### SCF Expansion: Requesting SCF

- OMHA will send the *SCF Preliminary Notification* and *SCF Spreadsheet* to the appellant(s). The appellant will have **15 calendar days** from receipt of the *SCF Preliminary Notification* to file a complete SCF Request package.

The appellant request package must include the following items on a flash drive or a compact disc:

- ❖ *Request for SCF form*
- ❖ *SCF Agreement of Participation form*
- ❖ A complete *SCF Request Spreadsheet*: the responsibility of ensuring all claims meet SCF eligibility requirements lies with the appellant

\*We will presume the appellant received the preliminary notification within 5 calendar days of the date of the notification.

12



### SCF Expansion: Requesting SCF

- ❑ If an appellant objects to an appealed claim on the *SCF Spreadsheet* (e.g., the claim was never appealed) or believes some claims are missing from the spreadsheet, the SCF administrative team will work with the appellant to address any issues and produce a revised *SCF Spreadsheet*, if necessary. Appellants may not request that claims be removed from the spreadsheet simply because they prefer Administrative Law Judge review of specific claims.

13



### SCF Expansion: Requesting SCF

- ❑ Once OMHA has received the appellant's complete SCF package, OMHA will issue a confirmation notice to the appellant and CMS identifying all of the appealed claims which will be subject to the settlement conference.

14



### SCF Expansion: Requesting SCF

- ❑ OMHA facilitates Pre-Settlement Conference Call between all parties
- ❑ OMHA facilitates Settlement Conference between all parties

15



### SCF Expansion: Completing the SCF Process

- ❑ If an agreement is reached:
  - ❖ The OMHA facilitators will draft a settlement agreement in accordance with the instructions of all of the parties.
  - ❖ CMS and the appellant will sign the settlement agreement. The appellant must sign the agreement on the date of the settlement conference and not later.

16



### SCF Expansion: Completing the SCF Process

- ❑ If an agreement is reached:
  - ❖ OMHA will combine the appealed claims subject to the settlement agreement into one Administrative Law Judge Appeal number for administrative efficiency and issue a single dismissal order.
  - ❖ CMS Medicare Administrative Contractors (MACs) will effectuate the settlement agreement.

17



### SCF Expansion: Completing the SCF Process

- ❑ If the an agreement is not reached, the appealed claims will be returned to their prior place in OMHA's docket:
  - ❖ If the appeal(s) was assigned to a judge, it will return to the same judge.
  - ❖ If the appeal(s) had not been assigned to a judge, it will return to its original place in the queue for assignment (based on the date the request for hearing was received.)

18



## Don't Wait...Facilitate!

Andrew B. Wachler, Esq.  
Wachler & Associates, P.C.  
210 E. Third St., Ste. 204  
Royal Oak, MI 48067  
(248) 544-0888  
awachler@wachler.com  
www.wachler.com



## SCF Phase III: Hospitals

- Claims that were eligible for the CMS Part A Hospital Appeals Settlement option ("68% Settlement") are ineligible regardless of whether the provider participated in the 68% Settlement
- 68% Settlement eligibility criteria:
  - (1) The claim was denied by an entity which conducted review on behalf of CMS;
  - (2) The claim was not for services or items furnished to a Medicare Part C enrollee;
  - (3) The claim was denied based upon an inappropriate setting determination (a "patient status" denial);
  - (4) The first day of admission was before October 1, 2013;
  - (5) The hospital timely appealed the denial;
  - (6) As of the date the administrative agreement is executed by the hospital and submitted to CMS the claim was either still pending at the Medicare Administrative Contractor (MAC), QIC, ALI or DAB level or the hospital hadn't yet exhausted its appeal rights; and
  - (7) The hospital did not receive payment and/or bill for the service as a Part B claim



## SCF Phase III: Hospitals (cont.)

- 68% Settlement was limited to acute care and critical access hospitals
  - Hospitals that were ineligible for the 68% Settlement, but are eligible for SCF Phase III:
    - Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)
    - Inpatient Rehabilitation Facilities
    - Long Term Care hospitals
    - Cancer hospitals
    - Children's hospitals
    - Acute care and critical access hospitals with pending FCA litigation or investigations
- 68% Settlement was limited to "patient-status" appeals
  - Hospital claims that were ineligible for the 68% Settlement, but may be eligible for SCF Phase III:
    - DRG denials
    - Underlying service not medically necessary and reasonable in any setting
    - Insufficient documentation of conservative treatment prior to a surgical procedure



## SCF Phase III: Home Health Agencies

- Beginning April 1, 2011, regulations required physicians document a "brief narrative" explaining how the circumstances of the face-to-face encounter supported the beneficiary's homebound status and need for skilled services
- 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



## SCF Phase III: Hospices

- RAC Approved Issues
  - Extensive length of stay
  - Excessive units of physician services
- OIG Work Plan (FY 2016)
  - Focus on the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care
- Common Medicare hospice audit risk areas
  - Documentation does not support terminal prognosis of six months or less
  - Hospice recertification requirements
  - Respite care



## SCF Phase III: Skilled Nursing Facilities (SNFs)

- CMS Press Release (March 2016) with SNF Utilization and Payment Data
  - Included information on two categories of RUGs that will likely be a focus of Medicare contractor audits: Ultra-high (RU) and Very high (RV) rehabilitation RUGs.
  - CMS found that for these two RUGs, the amount of therapy provided is often very close to the minimum amount of minutes needed to qualify a patient for these categories
- Common Medicare SNF audit risk areas
  - Billing inaccurate RUG levels
  - Medical review of therapy claims exceeding \$3,700 threshold
  - Consolidated billing
  - Lack of documentation to support skilled services



## 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](#)
  - 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: 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 Strategy: Key Considerations

- Usually 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)
    - Consolidation of claims pending before the same ALJ
  - Time value of money
  - Certainty value of settlement
  - Interest on recouped claims (“935 interest”)



## SCF Strategy: Key Considerations (cont.)

- 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 Strategy: “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 Strategy: Key Considerations (cont.)

- How strong are your claims on the merits?
- Dismissal of appeal, if settled
- Claims remain denied, if settled
  - Will not improve provider’s error rate
  - Cannot seek further reimbursement from beneficiary
    - E.g., if settled at 65% payable amount, cannot request 65% of copay
    - Secondary payer issue
    - What about “downstream” claims?
      - Example: A surgical claim is settled, but remains denied. What about the anesthesia claim?
      - “CMS acknowledges this issue and is looking into possible ways to allow for payment of these types of claims in the future.”



## 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?

Andrew B. Wachler, Esq.  
Wachler & Associates, P.C.  
210 E. Third St., Ste. 204  
Royal Oak, MI 48067  
(248) 544-0888  
awachler@wachler.com  
www.wachler.com