FREQUENTLY ASKED QUESTIONS

2016 Hospital Appeals Settlement for Fee-For-Service Denials Based on Patient Status Reviews for Admissions Prior to October 1, 2013

Last Updated: December *8*, 2016

A. GENERAL QUESTIONS:

1. Why is CMS offering a settlement again?

Through the prior administrative settlement process, CMS executed settlements with 2,022 hospitals, representing approximately 346,000 claims and paid approximately $1.47 billion in payments to providers. Some providers, however, did not take advantage of this process at that time. Therefore, CMS has decided to again make available an administrative settlement process open to any provider willing to withdraw their pending appeals in exchange for timely partial payment (66% of the net allowable amount). CMS encourages providers with patient status claims currently in the appeals process at level 3 or level 4 to request participation in this administrative settlement process to alleviate the administrative burden of current appeals and the associated litigation risk for both the provider and the Medicare program.

2. What authority does CMS have to do this type of settlement?

CMS is offering this settlement pursuant to the Social Security Act and CMS's regulations regarding claims collection and compromise at 42 C.F.R. §§ 401.601 and 401.613, and regarding compromise of overpayments at 42 C.F.R. § 405.376.

3. What is the deadline for a hospital to submit the Expression of Interest?

Providers should submit the Expression of Interest by January 31, 2017.

4. Is this settlement indicative of fault on behalf of CMS or the provider requesting the settlement?

The parties will make no admission of fault or liability with regard to the administratively-resolved eligible claims. This is an effort to quickly reduce the volume of inpatient claims currently in the appeals process.

5. Who is authorized to sign the administrative agreement on behalf of the provider?

The person who executes the administrative agreement represents and warrants that they are fully authorized to sign on behalf of the provider.

6. How long will it take CMS to complete the settlement?

CMS and its contractors will work as expediently as possible to validate the eligible claim spreadsheet submitted. Once the claims are validated, payment will be made within 180 days of a signed agreement from CMS.

7. How are Recovery Auditor contingency fees impacted by this settlement offer?

Recovery Auditor contingency fees are governed by contract requirements and will be handled accordingly.

8. What happens if we do not proceed with settlement after submitting an Expression of Interest?

The settlement offer is completely voluntary. Providers who do not proceed with settlement after submitting an Expression of Interest will be unaffected and remain in the normal appeals process.

9. Will these claims be excluded from future audits by any/all auditing entity, e.g., MAC, RAC, QIO, CERT, and OIG?

Claims that have already been reviewed are always excluded from future review by a MAC and Recovery Auditor. Because CERT chooses claims randomly, it is possible that a handful of these claims will be selected for CERT review. This settlement does not impact reviews being conducted under the False Claims Act, so ZPIC or OIG reviews of potentially fraudulent claims will continue.

10. Can appeals of extrapolated overpayments that otherwise meet eligibility criteria be settled under this process?

A denial based on an extrapolation may be eligible for settlement through this process. However, for a claim to be included in settlement, it must have been part of the sample and be denied. The extrapolated universe of claims are not eligible. If a provider wishes to include extrapolated sample claims in settlement, and have the extrapolation re-calculated after settlement, the provider must contact the OIG to request re-calculation of the sample. CMS does not have any involvement in the re-calculation of an extrapolation.

11. We have paid out a lot of money to send denials to the ALJ level. How can we recoup on this if we agree to take the settlement?

CMS cannot repay costs associated with an appeal. Nevertheless, this opportunity eliminates any further administrative expense.

12. Why should we take a discount when we are likely to win at the ALJ?

A provider should assess its own risks and rewards offered through this settlement opportunity.

13. How will eligible claims that are the subject of the administrative agreement be characterized in the relevant CMS database (such as the Common Working File)? Will they be characterized as paid claims? Denied claims?

Claims included in this settlement will remain denied and the appeals will be dismissed.

14. Is the settlement for both Medicare FFS and Medicare Advantage cases in the appeal process? Will Medicare Advantage Plans be affected or encouraged to offer the same kind of settlement terms?

This settlement is only for eligible Medicare Fee-For-Service (FFS) claims.

15. Will CMS share our administrative agreement with the public?

CMS may be required to disclose copies of executed administrative agreements or information contained therein in response to a lawful request. With respect to the 2014 Hospital Appeal Settlement, CMS released the name, provider number, state, number of claims settled and amount paid to participating providers, in response to a Freedom of Information Act (FOIA) request.

16. Since claims involved in the settlement will remain <u>denied</u> in Medicare's system, what happens to any associated Skilled Nursing Facility (SNF) claims?

The beneficiary's patient status remains inpatient as of the time of the inpatient admission and is not changed to outpatient, because the beneficiary was formally admitted as an inpatient and there is no provision to change a beneficiary's status after he or she is discharged from the hospital. Therefore, the beneficiary's patient status remains inpatient, and this does not impact SNF eligibility. Please note all other eligibly criteria for SNF must be met.

17. Will claims involved in the settlement be used to calculate a provider's Additional Documentation Request limits for the Recovery Auditors?

No, claims settled through this resolution will not be used in any calculation to determine a provider's denial rate for purposes of establishing ADR limits.

18. Will hospitals know the net settlement value of the included eligible appeals before we sign the settlement agreement?

No, the net settlement amount for any provider will be determined after the settlement has been signed by the provider and CMS. The settlement percentage will be 66% of the net claim paid/payable amount.

19. From a process standpoint, what are some of the big differences between this Hospital Appeals Settlement Process and the one offered in 2014?

Under the 2016 process:

1. Providers will submit an Expression of Interest, and CMS will create a list of potentially eligible claim appeals, instead of the provider creating the list.
2. Providers will verify the list of potentially eligible claim appeals compiled by CMS, instead of the provider compiling and submitting a list of claims to CMS for verification.
3. Providers will sign the administrative agreement when they agree to the list, instead of signing the agreement first and then deciding to proceed with or abandon the process.
4. The MACs will price the claim appeals included in the agreement after the agreement has been signed by both parties, instead of pricing the claims up front.
5. There will only be one payment made, instead of two rounds of payment.

CMS believes that these changes will reduce stakeholder burden and speed up the process.

20. Can I edit or add columns/fields to the eligible claims spreadsheet?

No, providers may not add columns or reformat the spreadsheet. If providers make changes to the spreadsheet, CMS will reject the spreadsheet and the provider will have to restart the eligibility process.

B. ELIGIBILITY:

1. Which providers are eligible for the settlement?

The following facility types ARE ELIGIBLE to submit a settlement request:

- Acute Care Hospitals, including those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and Maryland waiver; and
- Critical Access Hospitals (paid under both Method I and II)

The following facility types are NOT eligible to submit a settlement request:

- Psychiatric hospitals paid under the Inpatient Psychiatric Facilities (IPF) PPS;
- Inpatient Rehabilitation Facilities (IRFs);
- Long-Term Care Hospitals (LTCHs);
- Cancer hospitals; and
- Children's hospitals.

A full definition of each of these facility types can be found at §1886(d) or §1820(c) of the Social Security Act.

2. Must Hospitals under common ownership or control submit a single administrative agreement and spreadsheet? Consider the following 2 examples:

- **EXAMPLE ONE: ABC Hospital Chain comprises five hospitals, and each hospital has its own provider number. Will CMS allow some of those hospitals to participate while the other ones might decide to continue with appeals?**

- **EXAMPLE TWO: XYZ Hospital Chain comprises five hospitals all under a single provider number. Will CMS allow some of those hospitals to participate while the other ones might decide to continue with appeals?**

The settlement process requires EACH PROVIDER NUMBER to submit a separate Expression of Interest. EACH ORGANIZATION WITH A PROVIDER NUMBER must choose to accept the settlement offer (allowing ALL of its eligible appeals to be dismissed), or choose to continue with appeals. Regarding the examples above:

- **EXAMPLE ONE**: Each hospital in the ABC Chain may decide whether to participate or not. If an ABC Hospital chooses to participate, it must include all claims from that provider number on its spreadsheet. If one ABC Hospital participates, that does not mean that all other ABC Hospitals have to. Each ABC Hospital can make its own decision whether to participate or not.

- **EXAMPLE TWO**: Because XYZ Hospital Chain has a single provider number, the XYZ Chain must decide whether to participate or not. If XYZ Chain chooses to participate, it must include all claims from its provider number on its spreadsheet.

3. Must a hospital settle all eligible appeals?

Yes, for the provider to receive any payment as part of this settlement, the provider must settle all eligible appeals. The provider may not choose to settle some claims and continue to appeal others.

4. What claims are eligible for settlement?

Claims are eligible to be included in a provider's request if:

- The claim was not for items/services provided to a Medicare Part C enrollee
- The claim was denied due to a patient status audit conducted by a Medicare contractor, on the basis that services may have been reasonable and necessary, but treatment on an inpatient basis was not, and
- The claim has a date of admission prior to October 1, 2013, and
- As of the date the provider signs and submits their first administrative agreement with the list of eligible claims:
    a. the appeal decision was still pending at the ALJ or DAB; **or**
    b. the provider had not yet exhausted their appeal rights at the ALJ or DAB levels

5. Why aren't Level 1 and Level 2 appeals eligible for this process?

CMS has determined that there are no patient status claim denial appeals at Level 1 and Level 2 with dates of admission prior to October 1, 2013 eligible for the settlement.

6. What if the hospital claim was denied for a reason other than "patient status," such as coding?

Provider inpatient claims denied for reasons **other than** patient status, when the "services may have been reasonable and necessary but treatment on an inpatient basis was not" are not eligible for this agreement.

7. Can we pick and choose the cases we want to settle? Or is an all or nothing selection?

All claims that meet the eligibility criteria must be included in the settlement.

8. Will inpatient rehabilitation facilities (IRF) be considered for this settlement?

No. IRFs are not eligible under this process.

9. If our acute hospital has an IRF and we have had RAC denials for both the acute and rehabilitation number, is the IRF eligible for the settlement offer?

Assuming you have one provider number for your IRF and one provider number for your acute care hospital, the acute care hospital is eligible to submit a settlement request. The IRF is not.

10. What categories of denials are included? Just complex RAC reviews, or also CERT, OIG, MAC pre-pay, RAC pre-pay, etc.?

If you meet the eligibility criteria as a hospital provider for patient status denials, all claim denials will be included. It does not matter who initiated the claim denial or whether the claim denial was made on a prepayment or a post-payment basis.

Note: For reviews conducted by a QIO, to be considered a claim denial, there must be a demand letter sent by the MAC to start the process of recouping the payment. Further, to be eligible for settlement all other requirements must be met.

11. Does it cover only short stay or does it cover minor surgery etc.?

The settlement offer is open to all patient status denials including minor surgery admissions denied because although the surgery was necessary, an inpatient stay was not.

12. Does this pertain to coding denials?

No, this settlement is for patient status denials only.

13. Do claims that were "technically denied" (non-submission of records) meet the criteria for this option?

No, claims that were denied for failure to submit medical records are not eligible for this settlement offer.

14. What must be prior to October 1, 2013? The Date of Service? The denial? The appeal? Or all three?

To be eligible for settlement, the claim's date of admission must be prior to 10/1/13.

15. Does it matter what step of the appeal process the claim is currently in? Or does the settlement only apply to appeals that are stuck at the ALJ level?

Because the date of admission for these claims is prior to October 1, 2013, CMS believes that all appeals are at level 3 or 4 (ALJ or DAB). A claim is eligible if there is a valid appeal pending at the ALJ or DAB level of appeal so long as all other criteria are met. A claim is also eligible if it is within the timeframe to be appealed to the ALJ or DAB so long as all other criteria are met. CMS has determined that there are no patient status claim denial appeals at level 1 and level 2 with dates of admission prior to October 1, 2013 eligible for the settlement.

16. What the cutoff date for "currently pending appeals" is as stated in the administrative agreement?

The important date is the date the provider signs the administrative agreement. If any appeals were decided prior to the date the provider signs the administrative agreement, that appeal and associated claims will be removed from the list of eligible claims on the spreadsheet.

17. Is the settlement offer restricted to appeals in process or can pending appeals that are being appealed to another level be included? Or can we attach past appeals that have been denied?

A claim is eligible for settlement if there is a valid appeal pending in the appeal process OR within the timeframe to be appealed to level 3 or 4 as of the date the provider submits its Expression of Interest request to CMS (so long as all other criteria are met).

18. How far back, regarding date of service can you appeal?

All claims with dates of admission prior to October 1, 2013 are eligible for settlement, regardless of how far back the date of admission goes, assuming the appeal is pending at any point at levels 3 & 4 (or within the timeframe to appeal to the next level of appeal so long as all other criteria are met).

EXAMPLE: A claim with a date of admission of January 24, 2009 is denied by the RAC, a valid appeal is submitted by the hospital and remains pending at the ALJ as of the date the provider signs the administrative agreement. This appeal is eligible for settlement.

19. Are hospital Distinct Part Units excluded (IP Rehab, IP Psych)? Are CAHs with distinct part Psychiatric Unit excluded?

Eligible claims under appeal by the acute care and critical access hospital unit may be submitted for resolution through the administrative agreement. Claim appeals involving other distinct units are not eligible for this resolution.

20. Is a case eligible for settlement if it started out as Diagnosis Related Group (DRG) coding denial, but during appeal review, was denied for incorrect patient status?

Yes, these are eligible for settlement (assuming all other claim eligibility criteria are met).

21. I just received a fully favorable decision from an appeals adjudicator on the Part A claim. Is that claim eligible for settlement?

No, those claims are not eligible under the settlement process. Since your appeal was fully favorable, it is no longer a pending appeal or within the timeframe to appeal to the next level. Your fully favorable appeal decision will be effectuated following our standard process.

22. Are claims eligible for settlement distinguished by the date of admission or date of discharge?

Claims eligible for settlement are based on date of admission, which must be before October 1, 2013.

23. If at some point in the process a claim is determined ineligible for settlement, will we be allowed to continue the normal appeal process for that claim?

Yes. This settlement is only for claims that meet the "eligible claims" criteria. Those claims determined ineligible for this settlement process will be allowed to continue in the normal appeals process.

24. We submitted a number of inpatient claims for procedures on the CMS inpatient-only list. The claims were denied saying that the services are more appropriate in an outpatient level of care. Are they eligible for settlement?

Yes. Because the decision to deny the claim was due, in part, to incorrect patient status, the claim is eligible for settlement assuming it meets the other eligibility criteria.

CMS review contractors identified many claims where the hospital listed an Inpatient Only procedure code on the claim, but the medical record indicates that a different procedure was actually performed, and the procedure actually performed was NOT on the Inpatient Only list. After the CMS review contractor determined the correct code, they also made a determination about whether the patient's care met the criteria for inpatient or outpatient hospital services.

25. Other than the traditional appeals process, is this process the only alternative process to go through for inpatient-only procedures that have been denied where we don't agree with the denial?

CMS review contractors identified many claims where the hospital listed an Inpatient Only procedure code on the claim, but the medical record indicates that a different procedure was actually performed, and the procedure actually performed was NOT on the Inpatient Only list. After the CMS review contractor determined the correct code, they also made a determination about whether the patient's care met the criteria for inpatient or outpatient hospital services. Because the decision to deny the claim was due, in part, to incorrect patient status, the claim is eligible for settlement assuming it meets the other eligibility criteria.

This settlement process is completely voluntary. Providers are not required to submit an Expression of Interest request. If a provider does not submit an Expression of Interest request, they may continue in the appeal process. If a provider does submit the request, they must agree to settle all eligible claims. Providers may not choose to settle some claims and continue to appeal others.

26. Are QIO admission denials eligible for settlement?

No. Only claim denials are eligible for settlement, so long as all other requirements are met. A claim denial occurs when the MAC issues a demand letter for a case reviewed by the QIO.

27. Are QIO claim denials based on patient status reviews eligible for settlement?

Claim denials are eligible for settlement, so long as all other requirements are met. Note: For reviews conducted by a QIO, in order to be considered a claim denial, there must be a demand letter sent by the MAC to start the process of recouping the payment. Further, to be eligible for settlement, all other requirements must be met.

28. We have been trying to rebill some of our claims, but have faced significant delays and challenges. We have not yet received our payment, however with the rebilling of the claim, the appeal is no longer pending. Are these claims eligible for this settlement?

No. Whenever an inpatient claim appeal is no longer pending, such claims are not eligible for settlement. Under CMS Ruling 1455-R http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1455R.pdf, hospitals were allowed to rebill Part B for certain services as long as certain criteria were met. Assuming that rebilling requirements were met, those claims should be paid timely. Significant delays related to claim rebilling is a concern of CMS, and CMS is working with its contractors to determine why some providers may be experiencing delayed payment of rebilled claims. We will provide more information regarding the steps taken to alleviate delay once we have investigated this issue. CMS encourages you to return to this site for updates concerning this matter.

Updated 12/8/16

29. Can providers be excluded from settlement by CMS?

Yes, certain hospitals may be excluded from this process based on pending False Claims Act litigation or investigations. A provider that is excluded from settlement will receive a letter from CMS notifying of CMS' determination. *Providers who have filed for bankruptcy or who expect to file for bankruptcy are also excluded from settlement.*

30. If a provider submitted a signed administrative agreement as part of the 2014 Hospital Appeals Settlement Process, but later chose not to settle, are they eligible to participate in this process?

Yes. As long as the provider has claims that meet the eligibility criteria and did not receive payment under the 2014 Hospital Appeals Settlement Process, they are eligible to settle.

C. PROCESS:

1. Who is authorized to be the point of contact on the Expression of Interest?

Anyone can be listed as the provider's point of contact.

2. Can CMS clarify the Provider Number requested on the spreadsheet?

The 6-digit Provider Number is also known as the CMS Certification Number (CCN), Online Survey Certification and Reporting (OSCAR) or Provider Transaction Access Number (PTAN).

3. Can providers include multiple provider numbers on one Expression of Interest request?

No, CMS needs to receive one Expression of Interest per provider number. If a chain hospital has multiple provider numbers, a separate Expression of Interest must be submitted for each. The Expression of Interest spreadsheet can include multiple National Provider Identifications (NPIs) associated with each provider number.

4. Will the provider have the opportunity to review the final settlement amount before CMS executes the administrative agreement?

No. The settlement amount will be priced by the MAC at effectuation after both the provider and CMS have signed the agreement. Providers will have a chance to review the final listing of eligible claims before they sign the agreement.

5. How will the settlement affect the claim's history?

The claim will remain as denied and no claim-level adjustments will take place. A Medicare Summary notice (MSN) will not be sent to the beneficiary.

6. Is the 66% partial payment negotiable?

No.

7. Is the 66% settlement offer calculated per claim or is the 66% applied to the sum of all the claims submitted?

The 66% is calculated per claim and then summed into one lump sum payment.

8. Payment at 66% of what amount? Expected Inpatient DRG or expected Ambulatory Patient Classification (APC)?

The payment will be 66% of the inpatient net paid/payable amount.

9. Do we have to resubmit all the claims or can we just fill out the Expression of Interest?

Claims included in a settlement will not be resubmitted by the provider. Nor will they be reprocessed by the MAC. Instead, the MAC will issue one lump sum payment and the claim will remain denied in the system.

10. How will payment be made? Will CMS clearly and specifically tell which claims have been paid? How will the payment be handled, i.e. patient level or lump sum?

Payment will be made by the MAC in one lump sum payment. Before the lump sum payment, CMS will email the hospital a file containing a list of all claims included in that payment.

11. Will there be account level information with the payment to verify on an account level once the account is settled?

Payment will be made by the MAC in one lump sum payment. Before the lump sum payment, CMS will email the hospital a file containing a list of all claims included in that payment.

12. Will there be a Round 2 similar to the 2014 Hospital Appeals Settlement Process?

No, all claims will be handled in one round this time. There will be no Round 2.

13. Are there a minimum or maximum number of claims that will be accepted on the application?

There is no minimum or maximum number of claims that can be included in a settlement request.

14. Do we still have appeal rights if we disagree with your assessment?

After the Expression of Interest, the list of claims will be sent to the provider for verification. The provider has an opportunity to add/remove claims from the list by submitting an Eligibility Determination Request to CMS (which will be verified by CMS). Once the provider has verified the list, the provider has 2 choices:

1. Abandon the settlement process or
2. Proceed with the settlement process.

Providers that choose to proceed with the settlement process are agreeing to dismissal of their pending appeals and waiver of their appeal rights for claims that are within the timeframe to file an appeal for all eligible claims. Providers who disagree with the CMS list of claims should abandon the process and remain in the normal appeal process.

15. Should the claim spreadsheet be sent securely since it includes PHI?

The spreadsheet should be encrypted when it is sent.

16. How will other insurance payments in coordination of benefits situations be affected by the settlement agreement?

If the claim is included in the settlement, the provider will receive 66% of the net payable amount, although the claims will remain as denied in CMS systems. A provider's obligation to other payers will be determined by existing law and/or the provider's existing arrangements or agreements with those other payers governing such situations.

17. How will payments be affected if the claim was for a dual-eligible beneficiary (Medicare and Medicaid)?

If the claim is included in the settlement, the provider will receive 66% of the net payable amount. As an enrolled hospital in a Medicaid program, hospitals have an obligation to notify the state Medicaid agency when they receive payment from another payer for care furnished to a dual-eligible beneficiary. Since the claim was denied, and will remain denied in CMS systems, Medicaid may have made payment. If so, the state Medicaid agency may recover any payment made, up to the amount paid for a claim resolved through this settlement.

New 12/9/16

18. Will I receive a new 835 remittance advice for claim appeals settled under this process?

Yes, the lump sum payment should appear on the remittance advice. Information about the specific claim line will be available on the final claims payment spreadsheet.

New 12/9/16

19. I understand that the settlement is 66% of the net allowed/allowable amount. What happens if I do not agree with the MAC's calculations of the net allowed/allowable amount?

If you believe that there was a miscalculation on a claim appeal(s) specific allowed/allowable amount, you should contact your MAC in a timely fashion regarding the calculation. MACs can review the accuracy of the calculations.

D. APPEALS IMPACT:

Update 12/9/16

1. If we choose the settlement option, will we need to submit withdrawals for the applicable pending appeals?

If a provider finalizes a settlement agreement with CMS, they agree to have all eligible claims dismissed from the appeal process. The hospital is not required to submit withdrawals for the appeals. The finalized settlement agreement serves as consent to withdraw the eligible claim appeals. Therefore, the ALJ/DAB will dismiss any applicable cases based on the finalized settlement agreement. *The finalized settlement agreement serves as both the hospital's withdrawal of the eligible claim appeals and also as the dismissal of resolved appeals from OMHA or the DAB. No additional withdrawal or dismissal documents will be necessary or provided.*

2. If facilities elect to participate, do they forfeit appeal rights for all claims even if they are for issues other than patient status or just those eligible per the criteria?

No. Providers are only agreeing to dismissal of appeals of eligible claims. Eligible claims include those where a patient status denial occurred. The provider retains their full rights to appeal other types of denials.

New 12/9/16

3. If I have appeals that have recently had a decision rendered at the ALJ, are those eligible for settlement?

If you received an unfavorable ALJ decision that is within the timeframe to appeal to the DAB then the appeal can be included. Please note that due to timing considerations, this appeal will likely not be on your potentially eligible claims list.

New 12/9/16

4. My ALJ hearing is scheduled to occur during the HASP eligibility timeframe and I want to pursue the settlement option. What should I do?

Each provider may determine how it wishes to handle its scheduled hearings on an appeal by appeal basis.

If you choose to pursue the HASP 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 resolution via the CMS HASP and send copies of that correspondence to all other parties. Contact information for the ALJ team assigned to your appeal is available on the Notice of Hearing (see the top right-hand corner of the first page), or via the OMHA website at ALJ Appeal Status Information System (AASIS) using either the QIC or ALJ appeal number.

If you choose to pursue the HASP option and wish to attend your hearing as scheduled, you may do so until CMS receives your signed administrative agreement. Once CMS receives a provider's signed administrative agreement, that provider'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.

E. ABANDONING THE SETTLEMENT PROCESS :

1. What if the hospital wishes to withdraw from the settlement process?

Once a hospital signs the administrative agreement they may no longer withdraw from the settlement process.

F. PAYMENT: Note: The term "net paid" refers to claims denied on post-payment review. The term "net payable" refers to claims denied on pre-payment review.

1. What is the provider's refund responsibility related to the Beneficiary's co-insurance and deductible?

The providers refund responsibility is as follows:

a. If the Beneficiary co-insurance has been collected at the time CMS signs the administrative agreement, no refund is required.
b. If the Beneficiary co-insurance has not been collected at the time CMS signs the administrative agreement, the provider must cease collections.
c. If a Beneficiary repayment plan has been executed at the time CMS signs the administrative agreement, the provider may continue to collect the co-insurance in accordance with the repayment plan.

2. What happens to recoupment of overpayments for claims that are in the appeal process (or still within the timeframe to request an appeal review) that are part of the settlement request?

As part of the effectuation process at the MACs, recoupments will be suspended.

3. What is the "Net Paid/Payable amount"?

"Net paid/payable amount" means the original inpatient Part A claim net paid/payable amount; it excludes the out-of-pocket obligations that are included in the "gross" or "allowable" amounts.

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance: DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance

4. Are payments at 66% to be made against only the Medicare to-be-paid portion or against the whole allowable payment?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance.

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.

5. Could you give an example of a DRG payment and the net paid/payable amount?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.
- Here is an example:
  - DRG payment amount = $2,000
  - DSH add-on = $200
  - IME add-on = $150
  - Deductible = $600
  - Coinsurance = $100
  - Net Paid/Payment Amount = $2,000 + $200 + $150 - $600 - $100 = $1,650
  - Settlement amount for this claim would be 66% * $1,650 = $1,089

6. The settlement is 66% of the actual cash that Medicare originally paid, correct? Not including any patient responsibility portion?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.

7. Will any prior payment be recouped and the claim repaid under this agreement, or the difference only settled?

Each claim will be calculated individually, and the payment status will be aggregated in order to determine the lump sum payment.

G. INTEREST:

1. Does the settlement agreement include repayment of full interest that has already been recouped from the providers?

Yes, any interest paid by the hospital after the claim was denied will be refunded. In addition, if interest has accrued on claims that has not been paid, the accrued interest will be adjusted to zero. Each claim will be adjusted, and it will result in one lump sum payment made to the hospital.

2. Will providers receive interest for the claims under appeal?

No, interest will not be paid for the claims under appeal. Settlement payment of 66% of the net paid/payable amount will be "payment in full."

3. If we participate in the settlement, do we get paid any interest owed for post-payment recoupments?

No, interest will not be paid for the claims under appeal. Settlement payment of 66% of the net paid/payable amount will be "payment in full."

New 12/9/16

4. What resolution will the provider have if the amount of interest recouped was not correctly applied to the settlement payment?

If you believe that there was a miscalculation on recouped interest, you should contact your MAC. MACs can review the accuracy of the calculations.

H. COST REPORT:

1. Please discuss whether the claims subject to administrative resolution will count toward a provider's Medicare Part A percentage for GME purposes.

Claims will be remain as denied in CMS systems and will not be included for cost report purposes, including the GME Medicare Part A percentage.

2. How will this (the lump sum payment) be handled during cost report audits?

Lump sum payment will not be included for cost report purposes, and claims will remain denied.

3. **Providers may not bill beneficiaries for any unpaid cost-sharing amounts-what about uncollected deductibles/coinsurance due? May the provider claim this as Medicare Bad Debt?**

The claims will remain as denied in CMS systems. The hospital may not claim the uncollected deductible/coinsurance from these settled claims as Medicare Bad Debt for cost reporting purposes.

4. **Since there is no rebilling involved, how will these settled claims appear in the providers PS&R report?**

These claims will remain as denied in CMS systems and will not be included on the PS&R or cost report.

5. **Will the inpatient days be reduced?**

No, total inpatient days will remain unchanged on the cost report.

6. **If we agree to the settlement, will this affect any other reimbursement or payment such as GME/DSH dollars?**

The 66% settlement payment includes an allowance for claim add-on payments. However, the data will not be used for cost reporting purposes.

7. **Since the claims will not be reprocessed, will this impact open cost reports, DSH, or medical education?**

The 66% settlement payment includes an allowance for claim add-on payments. However, the data will not be used for cost reporting purposes.

8. **Will the Medicare Cost Report be impacted by the administrative agreement?**

No. The administrative agreement results in 1 lump-sum payment to the provider. Claims and the cost reports will not be adjusted for any reason. This includes reimbursement for Disproportionate Share (DSH) payments, Indirect Medical Education (IME), Graduate Medical Education (GME), and any other payments made on the cost report.

I. REBILLING:

1. If the Part B rebilling payment is more than the 66% payment, would the greater payment be made?

No, this settlement provides for 66% of the net paid amount for each eligible denied inpatient claim.

2. If we choose to rebill claims to part B, does the 12 month from date of service rule still apply?

If you accept the settlement, rebilling is not required or permitted. If you do not accept the settlement and instead elect to pursue your Part A claims through the appeals process and to rebill Part B claims, all rebilling rules, including the timely filing rules, remain in effect. Those rebilling rules are not affected by the availability of this settlement.

3. If I have submitted a request to withdraw my Part A claim appeal, but have not yet received a dismissal letter, is my claim eligible for settlement?

Yes, those claims are eligible under the settlement process, assuming all other eligibility requirements are met.

4. I have submitted a request to withdraw my Part A claim appeal and received a letter dismissing my Part A claim appeal, but have not yet submitted the Part B claim. Is my Part A claim eligible for settlement?

Yes, under certain circumstances. Per the definition of eligible claims in paragraph 1 of the administrative agreement, claims for which an appeal is currently pending in the appeal process, or claims for which an appeal is within the timeframe to request an appeal to the next level (as of the date the signed agreement is submitted) are eligible to be included in the settlement.

On the date the provider signs the administrative agreement, if the provider's request to withdraw an appeal was granted and the dismissal notice was issued, but there is still time for the dismissal to be reviewed at the next level of appeal (or for it to be vacated by the appeal adjudicator), then the appeal is considered pending. CMS considers these claims eligible for settlement assuming all other eligibility requirements are met. In this situation, since the appeal of the Part A claim is considered pending, and the hospital has not submitted a Part B claim, the Part A claim is eligible for settlement.

To assist with processing settlement requests, CMS encourages providers with such cases to include a copy of the dismissal letter along with their administrative agreement when submitting to CMS.

5. I have submitted a request to withdraw my Part A claim appeal and received a letter dismissing my Part A claim appeal. I have submitted the Part B claim, but I have not received payment from my Medicare Administrative Contractor (MAC). Is my Part A claim eligible for settlement?

Yes, under certain circumstances. Per the definition of eligible claims in paragraph 1 of the administrative agreement, claims for which an appeal is currently pending in the appeal process, or claims for which an appeal is within the timeframe to request an appeal to the next level (as of the date the provider signs the administrative agreement) are eligible for settlement (assuming all other eligibility requirements are met). On the date the provider signs the administrative agreement, if the provider's request to withdraw an appeal was granted and the dismissal notice was issued, but there is still time for the dismissal to be reviewed at the next level of appeal (or for it to be vacated by the appeal adjudicator), then the appeal is considered pending. CMS considers these claims eligible for settlement assuming all other eligibility requirements are met. In this situation, since the appeal of the Part A claim is considered pending, and the hospital has submitted a Part B claim but has not received payment, the Part A claim is eligible for settlement. The hospital cannot receive both the settlement and payment for Part B inpatient services.

6. Following denial of my Part A claim, I submitted a Part B claim and have already received payment. Is that Part A claim eligible for settlement?

No. Because the provider has already received Part B payment for those services, the associated Part A claims are not eligible under this settlement process.

7. Due to the part B billing requirements, the claim was split into two TOB 121 vs. TOB 131 based on the inpatient order date/time. If payment was received on one claim but not the other, can the claim be included?

No, since at least a partial Part B payment was received the claim is not eligible for settlement.