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

2016 HOSPITAL APPEALS SETTLEMENT PROCESS

1. To request participation, the provider submits a completed Expression of Interest (EOI) document. The document can be found at http://go.cms.gov/HASP2016.
2. The completed EOI should be emailed to CMS at MedicareAppealsSettlement@cms.hhs.gov. The subject line should contain (*Provider Name-Provider Number-Expression of Interest*)
    a. One EOI is needed per provider number (6-digit PTAN).
    b. EOI's must be submitted on or before JANUARY 31, 2017.
3. Once the EOI is received by CMS, CMS will verify whether the provider meets eligibility criteria
    a. Some providers may be excluded from settlement based on False Claims Act cases or other pending investigations. If CMS determines that a provider is excluded from settlement, the hospital will receive a notification letter from CMS.
    b. Upon receipt of an EOI, if CMS is unable to locate eligible claims, the provider will be notified within 30 days of submitting their EOI.
4. If the provider is deemed eligible for settlement, the provider will receive an email from CMS with an Administrative Agreement (Agreement) and a claim appeal listing spreadsheet (spreadsheet).
5. Provider reviews Agreement and spreadsheet.
    a. If the provider agrees with the spreadsheet, provider proceeds to step 6.
    b. If the provider believes the spreadsheet contains claims that should not be included or the spreadsheet is missing claims, the provider should submit an Eligibility Determination Request (EDR) to CMS at MedicareAppealsSettement@cms.hhs.gov within 15 calendar days of receiving the Agreement.
        i. The EDR can be found http://go.cms.gov/HASP2016.
        ii. CMS and the hospital have 30 days to resolve any discrepancies. CMS will work with the provider to come to a consensus on the spreadsheet, which may include adding or removing claim appeals. If the provider agrees with the spreadsheet determinations, provider proceeds to step 6. Note: CMS retains the ability to make the final eligibility determination on claim appeals.

iii. If the provider does not agree to the claim appeals included, the provider can refrain from signing the Agreement and end the settlement process. The provider's appeal will remain in the normal process.

6. Provider signs Agreement and sends it back to CMS at MedicareAppealsSettlement@cms.hhs.gov within 15 calendar days of receipt. Provider should reply to the email in which they received Agreement and spreadsheet.
    a. If the Agreement or EDR is not received from provider within 15 calendar days from the day in which CMS sent the initial Agreement, provider is assumed to have ended the process and will be excluded from settlement.
    b. At this point, appeals included on the spreadsheet are stayed in the appeals process.
7. CMS signs the Agreement
    a. A copy of the fully executed agreement will be sent to the provider once signed by CMS.
8. The provider's applicable Medicare Administrative Contractor has up to 180 days to effectuate the Agreement. This process will include a final validation check of claim eligibility, pricing, and payment to the provider.
    a. There is a possibility that during the final validation, claims may be removed from settlement; the provider will be notified if this occurs.
9. The appeals associated with settled claims are dismissed, and appeals associated with un-settled claims, if any, are returned to their position in the appeals queue to continue in appeals process.