MLN Connects™

National Provider Call

Hospital Appeals Settlement: Introductory Information

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Presenters

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Agenda

I. Background

II. Proposed Settlement

III. Eligible Providers

IV. Eligible Claims

V. Initiation

VI. Validation

VII. Payment

VIII. Q+As

Question & Answer Process

During this call you may email your questions to Centers for Medicare & Medicaid Services (CMS) at:

MedicareSettlementFAQs@cms.hhs.gov

For questions submitted but not answered during this call, CMS will post answers to its website at:

http://go.cms.gov/InpatientHospitalReview

Background

- Office of Medicare Hearings and Appeals Federal Register Notice in January 2014:
  - Unprecedented growth in claim appeals
- Collaborative Efforts to Reduce ***Future*** Appeals:
  - Final Rule 1599 (published in August 2013), also known as the "2-Midnight Rule", clarified how Medicare contractors review inpatient hospital and critical access hospital (CAH) admissions for payment purposes
  - Part B billing: Interim Rule 1455-R and Final Rule 1599

Proposed Settlement

- To more quickly reduce the volume of patient status claim denials ***currently*** pending appeal, CMS is providing a process for resolving patient status determinations that are:
  - Pending appeal or
  - within the timeframe to request an appeal review

Proposed Settlement

- CMS is proposing to make a partial payment:
  - 68% percent of the net payable amount of the denied inpatient claim
  - Hospitals agree to the dismissal of all associated claim appeals
    - **This settlement includes all eligible claims. Providers* may not choose to settle some of these claims and not others.**
  - Accept the settlement as final administrative and legal resolution of the eligible claims

*Provider refers to an entity with a 6-digit provider number, also known as the provider's CCN, OSCAR, or PTAN number

Proposed Settlement: Eligible Providers

- The following facility types are generally ELIGIBLE to submit a settlement request:
  - Acute Care Hospitals, including those paid via Prospective Payment System (PPS), Periodic Interim Payment (PIP), and Maryland waiver;
  - Critical Access Hospitals (CAH)
- The following facility types are NOT ELIGIBLE to submit a settlement request:
  - Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS);
  - Inpatient Rehabilitation Facilities (IRFs);
  - Long-Term Care Hospitals (LTCHs);
  - Cancer hospitals; and
  - Children's hospitals.

Proposed Settlement: Eligible Claims

- Claim pending appeal or within the timeframe to request appeal review
- Denial based on the appropriateness of the inpatient admission (patient status review)
- Date of Admission prior to 10/1/2013
- Not previously withdrawn/ billed for Part B payment

Proposed Settlement: Initiation

- Hospitals will send to CMS (MedicareAppealsSettlement@cms.hhs.gov):

    1. Hospital Signed Administrative Agreement*
    2. Spreadsheet of Claims/ Appeals Numbers*

- Hospitals agree to stay appeals during validation process

- Initial settlement requests are due to CMS on or before October 31, 2014

* The documents above, as well as an instruction sheet for completion, are available for download at http://go.cms.gov/InpatientHospitalReview

Proposed Settlement: Validation

- CMS and its contractors will review the hospital provided data against their own information
  - For claims which CMS agrees with the hospital:
    - Medicare Administrative Contractor (MAC) sends agreement lists to hospital for final review
    - Hospital sends CMS either
      - Confirmation to proceed, or
      - Notice of abandonment
    - CMS signs agreement
    - MAC will effectuate the payment
    - Appeal entities will dismiss associated appeals

Proposed Settlement: Validation

- When CMS finds discrepancies:
  - CMS may add additional eligible claims
  - MAC sends disagreements/additions to hospital for review
    - if hospital agrees - resubmit revised spreadsheet and administrative agreement
    - if hospital disagrees - MAC and the hospital will have discussions
  - MAC effectuates a second payment based on Round 2 validation
  - Appeal entities will dismiss associated appeals

Proposed Settlement: Payment

- Single* payment (EFT or otherwise) per hospital provider number or per owner or operator of multiple setting hospitals
- Payment within 60 days of effective date of the Agreement (i.e. co-signed by both parties)
- Provider shall not seek additional payment from Medicare beneficiary or collect any deductible or coinsurance amount
  - May retain amounts already paid

*A second payment may be made if CMS/contractors disagree with one or more of the claims on the initial hospital list

Resources

- Website: http://go.cms.gov/InpatientHospitalReview
  *(*Note- web address is case sensitive)*

- Send Settlement Requests to CMS at:
  - MedicareAppealsSettlement@cms.hhs.gov

- Send Questions to CMS at:
  - MedicareSettlementFAQs@cms.hhs.gov

Question & Answer Session

Acronyms in this Presentation

- **ALJ-** Administrative Law Judge
- **CAH-** Critical Access Hospital
- **CMS-** Centers for Medicare & Medicaid Services
- **DAB-** Departmental Appeals Board
- **EFT-** Electronic Funds Transfer
- **IPF PPS-** Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System
- **IRF-** Inpatient Rehabilitation Facility
- **LTCH-** Long-Term Care Hospitals
- **MAC-** Medicare Administrative Contractor
- **OMHA-** Office of Medicare Hearings and Appeals
- **PIP-** Periodic Interim Payment
- **QIC-** Qualified Independent Contractors

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