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Centers for Medicare & Medicaid Services
Hospital Appeals Settlement Update
MLN Connects National Provider Call
Moderator: Diane Maupai
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Contents

Operator: At this time I would like to welcome everyone to the today's MLN Connects National Provider Call. All lines will remain on a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Diane Maupai. Thank you. You may begin.

Announcements and Introduction

Diane Maupai: Hello everyone and thanks for joining us today. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore, and I'll be serving as your moderator today. I'd like to welcome you to this National Provider Call, which will provide an update on the Hospital Appeals Settlement. Today's National Provider Call is part of the Medicare Learning Network. During this call CMS experts will be discussing the CMS settlement — the settlement that CMS has offered to acute care hospitals and critical access hospitals for resolving patients' status denials.

Before we get started, I have a few announcements. You should have received a link to the slide presentation for today's call in previous registration emails. If you've not already done so, please view or download the presentation from the following URL, www.cms.gov/npc. Again that URL is www.cms.gov/npc. At the left side of the webpage select National Provider Calls and Events, then select the October 9th call from the list. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available. It typically takes about 2 weeks. And last, for this call registrants were given the opportunity to submit questions. We thank everyone who submitted questions. We've addressed many of those questions during today — we will address many of those questions during today's presentation. We've also posted Hospital Settlement FAQs on the Inpatient Hospital Reviews webpage.

At this time let's move to slide 4, and I will introduce our CMS speakers. From the Office of Financial Management, we have Melanie Combs-Dyer, the Director of the Provider Compliance Group, and Mark Korpela, Acting Deputy Director of the Financial Services Group. From the Center for Medicare, we have Maria Ramirez, Director of the Division of Appeals Operations.

Moving to slide 5. Melanie is going to start us off with background and a high-level overview of the settlement. Maria will cover rebilling. Mark will discuss payment and the remittance advice, and Melanie will be back to provide helpful hints and resources. We will then open the line for your questions.

Now on slide 6, it indicates that you can submit – you can email questions during the call, that's incorrect. We're going to be taking questions live during this call. However, if

you still have a question after the call, you can submit it to that email address that you see on slide 6. And with that, I will turn the call over to Melanie.

Presentation

Melanie Combs-Dyer: Thank you Diane. This is Melanie Combs-Dyer and I have just a couple of points before I dive into slide 7. First, I want to say that we are pleased in the interest that we have been seeing in our settlement program. Lots of hospitals have submitted settlement requests, and we have gotten a ton of questions into our FAQ mailbox. We really think that this is a mutually beneficial program to both hospitals and the Government, and we're working really hard to get all of those questions answered as quickly as we can. I would encourage everyone to check our website frequently as we are updating the FAQ list several times each week.

Next, I'd like point out that there seems to be a misperception that some folks have that this settlement program is all about Recovery Auditor claims, and that is not the case. This is for any claim that meets the criteria, which we'll be discussing in a minute, the eligibility criteria. And it doesn't matter if the claim denial was issued by the Recovery Auditor, by a MAC, by a ZPIC — we just want to make sure that everyone understands that this is a broad program.

And finally, I want to make sure that I reach out to — there have been a couple of folks who have been — who have let us know that they're having trouble using the CMS-formatted spreadsheet that appears on our website. You have asked if it is possible to submit in a different format. And up until now, we have been saying no, that it has to be the CMS format, but we now want to make sure that people know that we will be accepting — if you cannot use the CMS format, we will accept a format that is not in the CMS-specified format.

It may delay your processing time, however. So if you have the ability to use the CMS -formatted spreadsheet, we encourage you to use that one. If it's not possible, if you don't have somebody that can use that spreadsheet and you need to send it to us in a different format, we will accept it, though we cannot guarantee that yours will be processed as quickly as everyone else's. It's just going to take us longer to complete the validation due to the additional research that will be needed and manual processing of your nonstandard formatted spreadsheet.

Background

So now I'd like to quickly go through slide 7, which is the background. Again, I think many of you have heard this before. It was in January of 2014 that the Office of Medicare Hearings and Appeals put out their *Federal Register* notice that described the unprecedented growth in claim appeals. And CMS has been working hard to reduce future appeals. As you know, we put out the Part B rebilling ruling, CMS ruling 1455R,

that was published in March of 2013 and final rule 1599, also known as the 2-Midnight Rule, which was published in August of 2013.

Onto slide 8. But to more quickly reduce the volume of the current appeals, on August the 29th of this year, we announced this new settlement opportunity. We are proposing to make partial payment of 68 percent of the net payable amount of the denied inpatient claim to hospitals that agree to the dismissal of all associated claim appeals.

And it's important to note that this settlement includes all eligible claims. Providers cannot pick and choose their claims. I also want to point out our definition of provider. Again, it appears here at the bottom of slide 8. Provider refers to an entity with a six-digit provider number. Sometimes that's also called the provider CCN or OSCAR number or PTAN number, but if you have a six-digit provider number, you're the provider that we're talking about in these slides.

Eligibility

Slide 9 talked about eligible providers. To be an eligible provider you need to be an acute care hospital or a critical access hospital. Other facility types are not eligible. And on slides 10 and 11 are the criteria for eligible claims. And each of these criteria — all of these criteria must be met in order for a claim to be eligible for settlement. And I'm going to go through them one by one.

Number 1, it has to have been denied by a MAC, a RAC, CERT, OIG, or a ZPIC. Number 2, it has to be for fee-for-service Medicare—this is not Part C or Part D or managed care. The denial has to be based on a patient's status. Number 4, the date of admission has to be prior to 10/1 of 2013 — that is the admission. Some of you have asked, is it the discharge date? No, it's the admission date prior to 10/1/2013. Number 5, the hospital had to have filed their appeal timely. You can't wait 2 years and then file an appeal. You have to have filed during the normal timely appeals timeframe.

Number 6, as of the date that the hospital submits the initial agreement to CMS, the appeal was still pending or the hospital had not yet exhausted its appeal rights. Let me say that one again—this is an important one. As of the date that you submit your initial agreement to CMS, you either had the appeal still pending or you were within the timeframe to appeal to the next level. And Number 7, the hospital did not receive payment for the service as a Part B claim.

Now let me just tell you about two questions that have come in related to eligible claims. One question that has come in is, what happens if I'm no longer in the appeal process and I'm not eligible for the next level of appeal? I've been trying to rebill for a year, and I can't get my Part B claim to go through.

Well, in that scenario, you've met criteria Number 7, you've not been paid as a Part B claim, but you fail on criteria Number 6. You are no longer in the appeal process or eligible for the next level, and so that claim is not eligible for settlement.

Another question that we have gotten has to do with extrapolation. If I have a claim that is involved in an extrapolation, is that claim eligible for settlement?

And we've answered this question in FAQ number A13, and the answer there is, being involved in an extrapolation does not make a claim ineligible for settlement. So if a claim was sampled as part of an extrapolation case and it was reviewed and denied and it meets all of the other criteria that we've listed out here, one through seven, then yes, that claim can be included in the settlement process.

Now to learn what impact that settled claim from the sample might have on the universe and the projected overpayment, you would have to contact the entity who conducted the extrapolation review. So you may have to contact the ZPIC or you may have to contact the OIG or MAC or whoever did that extrapolation review to see. I know that oftentimes if a claim in the appeal process — if you win on appeal — that does have an impact on the settlement — I'm sorry, on the extrapolation amount. I don't know what that would be in these cases. You would have to contact the ZPIC, the MAC, or the OIG to find out.

Slide 12 talks about the process, how you go about getting into this process. You need to send to our mailbox, MedicareAppealsSettlement@cms.hhs.gov, two things:

- Number one – a signed Administrator Agreement, and
- Number two – a spreadsheet of claims and appeals numbers.

You can find both of those documents out on our website. And you have to agree to stay the appeal during the validation process. And the due date for submitting that email to us with those two attachments is October 31st, of 2014. Again, the website appears at the bottom of slide 12; it's go.cms.gov/InpatientHospitalReview.

Slide 13 talks about the validation process. CMS and our contractors will be validating the data that you submit against our own data and we — if we agree with you, the MAC will be sending you back an email, and it will contain a list of all of the agreed upon claims or a list of both the agree and the disagree claims. You then have to make a decision about whether or not you want to proceed or abandon the process. And you need to let us know within 14 days. You can either say yes, I'd like to proceed, or you just let us know that nope, you've decided that you would like to continue in the appeals process and you do not want to be part of the settlement process.

If we get an email from you saying that you want to proceed, we will then sign the Administrative Agreement and the MAC will effectuate the payment. And then the appeal entities will dismiss the associated appeals.

On slide 14 you can see how the payment process is going to work. It will be a single payment, electronic funds transfer usually. Sometimes — you see there's an asterisk next to single — sometimes there could be a second payment if there is some disagreed claims that are going to go through a round 2 process. But it's, generally speaking, one or two payments per hospital provider number that will be receiving those payments. We'll make payment within 60 days of the effective date of the Administrative Agreement. That is when both parties have signed, that starts the 60-day clock. And the provider must agree not to seek additional payment from the beneficiary or collect a deductible or coinsurance amount. But you can retain any amounts that have already been collected.

At this point I would like to point out that we've gotten a number of questions about rebilling scenarios — under which rebilling scenarios are the claims eligible for settlement and under which scenarios are they not eligible for settlement? And Maria Ramirez will be walking through those now.

Keypad Polling

Diane Maupai: Actually, thank you Melanie. At this time, we're going to pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there'll be a few moments of silence while we tabulate the results. Salema, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Once again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Thank you for your participation. I now would like to turn the call back over to Ms. Maupai.

Presentation continued

Diane Maupai: Thank you, I'm now going to turn the call over to Maria to talk about rebilling.

Rebilling

Maria Ramirez: Thank you Diane. So as Melanie was mentioning on slides 10 and 11, assuming that all requirements are met to participate in the settlement process, rebilling Part A claims are eligible if the provider has not received payment for the Part B claim as of the date of the — as of the date that the settlement is submitted. Some scenarios that based on questions that we have received are:

- If the provider requested or submitted a request to withdraw the Part A claim but has not received the dismissal letter from the entity adjudicating the claims,
- The provider receives the dismissal letter but has not submitted the Part B claim for payment, and
- If the provider has received a dismissal notice and submitted the Part B claim but has not yet received payment.

Those claims are eligible for the settlement process.

Moving on to slide 16. Two scenarios that we came up with that would not be eligible for a settlement would be claims for which a provider has received a dismissal, submitted the Part B claim, and has already received payment. And following a denial of a Part A claim, the provider submits a Part B claim and has already received payment. And now I'll turn it to Mark Korpela.

Secondary Payer Coordination of Benefit Claims and Remittance Advice

Mark Korpela: Thanks Maria. We received numerous questions regarding other insurance payments, and I'm going to address that generally. These questions pertain and may be sent in as Medicare secondary payer coordination of benefit claims questions.

Basically the answer is, the claims will remain as denied in the CMS systems—the inpatient claims will. So CMS expects that other payers, including secondary payers, will continue to follow the normal processes for addressing claims denied by Medicare. So basically, we will not be instructing other payers how to handle the claims; they should follow the normal process.

Slide 18. We also received questions on where the payments will appear on remittance advices.

So when, unfortunately, they're going to appear on two different places on the same remittance. If there was a prepayment denial, that'll be reported on the settlement payments line in the summary section. This is the same remittance that you would see

on your normal claim payment. So it would be on the settlement payments line for prepayment denials. Postpayment claim denials will be reported on the refund line in that same section. So again, it's the same remittance advice you're used to seeing with your claims, and there are just these two lines being used.

We're currently working with our contractors so they will issue an email to you in advance of that remittance so you know that the payment will be appearing soon on the remittance advice. We also will have an update to you as questions soon to address that. So everything I just said, you'll see in an update, too, soon.

Helpful Hints

Melanie Combs-Dyer: This is Melanie, and I will pick up on slide 19. I'm going to be going over a couple of helpful hints. These are things that we have seen come into our mailbox and we want to make sure that you guys can learn sort of some lessons from others who have gone before you.

Number 1 is just a reminder as to the mailbox where you need to send your settlement request and the suggestion that you use a particular subject line. You'll see it listed here — it's the provider request for settlement agreement from, and you put in your provider name and then you put in your provider number. And we encourage you to use that format. If you don't use that format for the subject line, we will continue to process your request, but it does help us speed things along if you can put it in that format. Please do not send questions to that mailbox. There's a different mailbox where you are to submit questions. I believe that appears on slide 6 and it has the letter FAQ in the email line.

Number 2 is a reminder that we really need to be able to read the Administrative Agreement, particularly the name of your hospital. There was an early version of the PDF file that appeared on our website that would cut off the name of the hospital if they had a long name. We have corrected that. And so if you're having trouble getting your name to appear on the PDF, go back to our website and download the latest version and see if that doesn't help. If, for whatever reason, you cannot get your name to fit in the PDF that we currently have on the website, let us know and we will try to work something out. We have to be able to read your name on the Administrative Agreement to proceed. It will be rejected if we can't read your name.

Number 3 is that we need to have a single Excel spreadsheet. You cannot send us one email that has three spreadsheets. We need one email that has an Administrative Agreement and a spreadsheet. So one agreement and one spreadsheet per email. Again, as I mentioned earlier, we do encourage providers to use the CMS formatted spreadsheet, but we will not reject if you use your own spreadsheet. It just may delay the processing.

Slide 20. On number 4 — talks about how we really need you to try to complete the spreadsheet in its entirety. There is a tab on the spreadsheet that contains a data dictionary that will help you define the terms that are used there, but the data dictionary is not where we want you to insert data. We've had to reject one or two where people have filled out their information actually in the data dictionary, and that was not the intent. The intent is that each row on the spreadsheet is where you will enter your claim information.

Also, you need to complete the header or the provider-level data at the top of each spreadsheet. We will reject it if that comes in blank.

Number 5, the DCN is generally a number that is at least 14 characters long, that's in column B. There have been a couple of you who have switched your appeal number and your DCN number, and that makes it very hard for us to process. So keep in mind, it's DCN, it's 14 characters long. Your appeal number, which is in column F, should be the last known number. If it's at the QIC or at the ALJ, it comes in the format that you see here — it's a number and then a dash and then a bunch of numbers. And the last known number from the Departmental Appeals Board comes in a format that usually starts with the letter M and then it has a dash and then a two-digit number to reflect the year and then a couple of more numbers after that.

Resources

Slide 21 talks about the resources. This is where you can get more information, all of those downloads and the FAQs that I was talking about appear at our websites, go.cms.gov/InpatientHospitalReview, the email box where you can send your settlement request, and the email address to which you can send your questions.

Question-and-Answer Session

And that brings us to our question-and-answer session. We're ready to take questions now.

Diane Maupai: Thank you Melanie. Our experts will now be taking your questions. Before we begin, I'd like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue and we'll address additional questions as time permits. All right, Salema, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line

will remain open during the time you are asking your question so anything that you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

The first question comes from the line of Dave Smith.

Dave Smith: All right, with regard to the providers that had the denials or so forth, would that also include the QIO?

Melanie Combs-Dyer: This is Melanie, and we don't know of any patient status denials that have been issued by the QIO.

Dave Smith: So I guess that's a no?

Melanie Combs-Dyer: That's a no.

Dave Smith: Thank you.

Melanie Combs-Dyer: You're welcome.

Operator: The next question comes from the line of Joy Cagle.

Joy Cagle: Yes, hello, this is Joy Cagle at Hugh Chatham Hospital in Elkin, North Carolina. My question is, Ms. Combs-Dyer said one thing about the Part B rebilling and Ms. Ramirez said the opposite. Could you all clarify whether the unpaid Part B rebills are or are not eligible and how will CMS deal with the MACs who are stonewalling payments on those? Thank you.

Melanie Combs-Dyer: I don't know that we said anything in conflict. I think what I said is that you have to meet both of the criteria that appear on slide 11. You have to be in the appeal process and to have not received Part B payment. And I don't think that conflicts with what Maria said. Maria, do you want to reiterate what you said?

Maria Ramirez: Yes. No, I don't think that there was any disagreement with what Melanie stated or what I stated. So essentially, the scenarios that I went over, if you are in the appeals process, you have requested that the entity that's adjudicating your claim withdraw your claim, you have received the dismissal, have not received the dismissal — as long as you haven't received payment, those claims are eligible for the settlement.

Melanie Combs-Dyer: And this is Melanie, I'll just reiterate, at the bottom of slide 15, which is the slide that Maria was working from, it says, "Assuming all other eligibility requirements are met." She was just describing the rebilling scenarios to further clarify what's meant by item Number 7 on the eligible claim list. "The hospital did not received payment for the services of Part B claim," trying to walk through some of those

scenarios. But it still has to meet all of the other criteria, including the criteria that say it's still in the appeal process. Joy, is that responsive to your question?

Joy Cagle: Yes. So, Part B rebills that have languished for going on a year now are not eligible and we just continue to battle with the MAC on those?

Melanie Combs-Dyer: If you are not currently in the appeal process, then this settlement is not — that claim is not eligible for this settlement.

Joy Cagle: OK, OK. So we will continue to battle it out with and submit back and forth, ping-ponging Part B rebills. Is that right? Because, I mean, that's a large portion. You know we really try to be, you know, very ethical about this when we can appeal this, when we rebill, because they're right. We should have billed it under Part B and we can't get payment.

Maria Ramirez: Hi Joy, this is Maria. Is it that you are having a hard time submitting your claims, your Part B claims to the MAC?

Joy Cagle: Yes, they're being rejected.

Maria Ramirez: OK, so you probably do need to work with the MAC to resolve those.

Joy Cagle: That's easier said than done, but thank you Ms. Ramirez. And one mechanical question, could you clarify the DCN number and the claim number on that column B, because since that alpha string changes we haven't tracked the alpha changes on every single appeal. We've, you know, counted it from the level of the RAC. And it would be so easy if you would just allow the provider to put in the claim number at the RAC level and then deal with that alpha string on your side that you know is it—NCFA or NAB or NCCA. Would that be, is that too much to ask?

Melanie Combs-Dyer: I would say try to put in the most recent claim number that you have for that claim or put in any claim number. I think, generally speaking, the contractors are usually able to find it. But the easiest way, the quickest way to facilitate the processing is for you to put in the most recent claim number that you have for that particular claim.

Joy Cagle: OK. I thank you, and I know I violated the number of questions. The last one, and I know everybody is going to want to know this, is the letter to beneficiary. We are still notifying the beneficiary that we're appealing so that we can stay in the game with our appeals. How is that going to be handled? Are they going to be notified by CMS that the appeal is no longer in process and it's been settled or you're going to leave that to the provider or is it just going …?

Maria Ramirez: Joy, are you talking about the ALJ level of appeal?

Joy Cagle: Correct. Yes, the notification to the beneficiary.

Maria Ramirez: So once we receive your settlement request, we — as part of the process — we are notifying the adjudicating entities that these claims are now entering the settlement process and so the system will pend those claims.

Joy Cagle: OK.

Maria Ramirez: And so we will — if you are settling the claims and you've already — if you've already submitted your request for ALJ hearing and you've already cc'd the beneficiaries, then, of course, there's nothing that you have to do now. If you are planning on submitting new requests for ALJ hearings and have not submitted it yet and have not submitted your settlement, just know that we are going to be pending those claims.

Joy Cagle: OK, I'm confused. Are you – so CMS is going to notify the beneficiary that the appeal is no longer in process, that it's been settled? I just …

Maria Ramirez: The claim is not technically settled until the settlement is finalized.

Joy Cagle: Presuming it's finalized, Ms. Ramirez.

Maria Ramirez: Presuming it's finalized, yes, we will notify the beneficiary.

Joy Kagel: Oh, great.

Hey, Joy, is there a telephone number that I can reach you at?

Joy Cagle: Yes, Ma'am, there sure is. It's XXX-XXX-XXXX.

Maria Ramirez: Thank you.

Joy Cagle: And I thank you, and I'll make room for the next person. Thank you ladies.

Maria Ramirez: Thank you.

Operator: The next question comes from the line of Jo Wedge.

Jo Wedge: Hi, I have a question in regards to something on the FAQs released yesterday. Specifically regards to question 21 on page 8, Part B eligibility. So I have review results, findings from the RAC contractor from 2011, yet we've not received a demand letter nor has the payment been recouped. So my understanding has always been that findings from a RAC contractor don't equate to a denial until you have a demand letter. They're

simply the audit finding at that point. Is that correct as I'm reading this question, that those claims would not be eligible?

Melanie Combs-Dyer: That is correct. If your claim has not been denied, then it is not eligible for this settlement process. Your understanding is correct.

Jo Wedge: So what happens if after we settle these claims and I have these cases of outstanding review results letters that we haven't really closed the loop on our end, the MAC now comes back and issues a demand letter after the fact? Can they do that?

Melanie Combs-Dyer: I would encourage you to contact us separately. We're here today to talk about the settlement process. I'm happy to work with you separately. You can send me an email; you can send it to the FAQ mailbox. We will get your answer addressed, just not in this forum.

Jo Wedge: OK, all right.

Diane Maupai: Thank you Melanie.

Operator: Your next question comes from the line of Mary Myslajek.

Mary Myslajek: Mary Myslajek from Hennepin County in Minneapolis. I'm still questioning the issue of the secondary payers. What's being described is that CMS or Medicare, the MAC, will send us a lump sum settlement. And, in my understanding, that you will not be issuing any notice to the beneficiary in your Medicare summary notice vehicle and you will not be sending us any individual account-level remittance information, which is where most Medicare secondary — or many Medicare secondary payers would get their information. So I'm just wondering what information would there be for a secondary payer to understand what the CMS final disposition of this claim is?

Mark Korpela: Sure, so, this is Mark Korpela. The final disposition of the claim is it's denied. You are settling. You are entering into a settlement agreement to receive 68 percent of the claim amount. The claim will still show as denied. It will be a settlement payment, which we explained on the remit will be, depending if it's prepay or postpay, on two different lines on the remit. You will not see a claim adjustment — the beneficiary will not see a claim adjustment and the — any other payer will not see a claim adjustment because it's a denied claim.

Mary Myslajek: OK, OK. Thank you.

Mark Korpela: You're welcome.

Operator: Your next question comes from the line of Andrea Dawes.

Andrea Dawes: My question is on the interest rate. Where do we find what the current interest rate is? We're trying to figure out if it was an ALJ or above, if it was favorable and we received interest and I've been trying to look up what the current interest, simple interest rate, is and I haven't been able to find it.

Maria Ramirez: Hi, this is Maria Ramirez and so the way that the effectuations process works is that once the claim is adjudicated and sent back for effectuations to the MAC, the MAC has this specific timeframe to calculate the amount that needs to be paid and a timeframe to pay. So if we go beyond that timeframe, that's when we would consider paying any kind of interest. Otherwise, we don't pay interest on claims that are just effectuated.

Andrea Dawes: No, no, no – because what we're trying to figure out is if we want to do this or not. So we're trying to get everything together. So we're trying to weigh our options and if, let's say, we didn't settle. But we want to know the interest because it talks about you figuring out the interest rate on your — like, let's say you won a favorable appeal at the ALJ level and it says like the 2000 interest — the 2008 interest rate was 11-point something. I can't find — where this — the 2014 interest rate is.

Mark Korpela: This is Mark Korpela. Unfortunately, in the room here, we don't know the exact location to give you that interest rate. If you'd like to send a question in through the mailbox; we will address it as soon as possible and send you simply the link through that website.

Andrea Dawes: OK, and the mailbox is in this presentation?

Melanie Combs-Dyer: It is. It has an FAQ in the title of the email box.

Andrea Dawes: Oh I see it, @cms@hhs.gov.

Maria Ramirez: Yes, slide 21.

Andrea Dawes: Thank you.

Operator: Your next question comes from the line of Ann-Marie Carducci.

Ann-Marie Carducci: Hi, it's Ann-Marie Carducci from Montefiore Medical Center. First of all, we have received medical necessity for setting denials from our QIO. So can we include them?

Melanie Combs-Dyer: Let us do some research on that. I was unaware that the QIO was making patient status determinations. I will — if you could — could you give me your telephone number so I can call you and get the specifics about these cases?

Ann-Marie Carducci: Sure. Should I email it to you?

Melanie Combs-Dyer: That would be great. You can send it to the FAQ mailbox and I will pick it up from there. Thank you Ann-Marie.

Ann-Marie Carducci: OK. But I wanted to – just another comment here. So we struggle with the 68 percent of the net payable amount of the claim. Would you consider, you know, we have the amount taken back from the end 432 code, for the RAC claim. Would it be a best guesstimate on the hospital side without going to each claim to take 68 percent of that to see what the reimbursement would be for RAC claim?

Melanie Combs-Dyer: I'll give you at least a partial answer and then Mark might want to add in. Once you submit your claim list to us, we pass it on to the Medicare Administrative Contractor. Then part of the validation process is them entering an exact dollar amount next to each claim. We then send — or the MAC sends — the whole list back to you. So you will see that exact amount for you to consider and make your decision about whether you want to proceed with the process or you want to abandon the process. Mark, did you want to add anything to that?

Mark Korpela: I'll add, it sound like you're trying to estimate before sending — how much claims. I don't know exactly what that RAC denial is you're referring to, but if it's the actual claims denial — if it was the bottom line of the claim that you're seeing a good denial, I believe that would be the amount that you base it off of, but...

Ann-Marie Carducci: It's actually the amount that was recouped.

Mark Korpela: Not the amount denied but the amount recouped?

Ann-Marie Carducci: Yes.

Mark Korpela: Well it sounds like by the way you're asking — that it could be two completely different numbers. So I don't know if we would have an answer for that. It would be the bottom line of the claim, the amount denied, that would have been paid on that claim. If the amount recouped equals that, then it's yes, that's the amount.

Ann-Marie Carducci: OK. All right, thank you.

Mark Korpela: You're welcome.

Operator: The next question comes from the line of Debbi Pedroza.

Debbi Pedroza: Hi, this is Debbi Pedroza from Nix Hospital in San Antonio and actually, with the questions before mine answered, the question about the remit and the single line items. I guess we will know because of the – what we encountered with the

incarcerated repayments was a nightmare. But it sounds like this is going to go a lot smoother because we will have the spreadsheet, we will know the exact dollar amount and be able to balance back.

Melanie Combs-Dyer: Oh good, glad to hear it. Thank you, Debbi.

Operator: The next question comes from the line of Amy Shaffner.

Amy Shaffner: Good morning, this is Amy Shaffner with Optum 360. And my question relates to a scenario, and I'm hoping you can help me understand it. If a facility entered into and sends the spreadsheet on say October 15th, we have five Level 2 denials that are pending to go into Level 3. That timeframe would expire let's say on October 20th, so 5 days after. Then 5 days after that, I decide, oh, my facility doesn't want to be in this and we pull everything. So the timeframe to appeal at Level 3 expired during that 14-day period where we can say if we want to be — really go forward or not. So what happens to those claims? Because we entered into the agreement thinking we were going to do it, but then we pulled out, but in the meantime the expiration date on that has expired. Do we get extra time on those appeals or are we out of luck? Or what happens to those appeals that expire during the timeframe we're trying to decide?

Maria Ramirez: Hi Debbie, this is Maria Ramirez again and I think that was one of the questions that we posted last week that essentially, yes, you will be able to opt back into the appeals process. So in your request for ALJ hearing you would have to explain to the ALJ that you were opting into this process and then you decided to opt out, and so your claims are eligible for the next level of appeals.

Amy Shaffner: Is there a certain timeframe then we have to do that, like immediately since, you know, or do we get a grace period? Or just as soon as we decide we're not doing it?

Melanie Combs-Dyer: Maria, this is Melanie, am I correct that once a hospital submits a spreadsheet to CMS, that freezes the process. And if they later choose to abandon the process, it picks right up where they left off. Is that correct?

Maria Ramirez: That is correct. But in her scenario she has Level 2 decisions that have not appealed to the next level. So they are eligible for appeal and have not been appealed to the next level. So in that situation, we would have to, you know, show that you were in the settlement process and decided to opt out. And I would suggest that you do that as expeditiously as possible just because you don't want to have your claims just sitting in a queue, that it's probably going to take even longer to be adjudicated.

Amy Shaffner: OK, thank you very, very much.

Melanie Combs-Dyer: And I would like to — to point you, Amy, to the FAQ that appears on page 16 in the current version—it is letter E, abandoning the settlement process, Number 1, "What if the hospital wishes to withdraw from the settlement process?" I think that will answer your question about what happens between — if you decide that you want to bow out and proceed with the appeal process. I think you'll find your written answer there.

Amy Shaffner: OK, thank you.

Operator: The next question comes from the line of Lauren Hopper.

Melanie Combs-Dyer: Lauren?

Lauren Hopper: Yes, our question has actually been answered. Thank you very much.

Operator: Your next question comes from the line of Steven Meyerson.

Steven Myerson: Yes, hi, this is Steven Meyerson with Accretive Healthcare. I have a question about the two-step process with the agreements. Reading the instructions on the website, after the hospital receives its list back from CMS, it says that the second step would be a second agreement sent –and then a second agreement signed by CMS. It actually says the original agreement, but it also says that the hospital needs to send a signed agreement with its second list when it responds to CMS. So I was wondering if — how this two-step process works and is it possible for a hospital to not sign a second agreement or to withdraw after the first settlement, the first payment is made?

Melanie Combs-Dyer: This is Melanie and, no. When you make your proceed or abandon decision, if you choose to proceed, you are agreeing to submit that second round if you had some disagrees. If everything was in agreement, then you will not have a second round. But if you've got an email back that had some agrees, some disagrees, your choice is to proceed, you are agreeing to submit a second round that would be a second Administrative Agreement and a second spreadsheet and will result in a second payment.

Steven Meyerson: But there has to be a second agreement signed and sent along with the adjusted spreadsheet and then CMS signs a second agreement?

Melanie Combs-Dyer: That is correct. And you will get a second EFT payment.

Steven Meyerson: OK. What happens if that process just falls apart and doesn't happen, you know the second agreement isn't sent or, you know, that just doesn't take place?

Melanie Combs-Dyer: We will continue to work with you until it does. If you decide that you want to proceed, we will continue the discussion period until we get to the end.

Steven Meyerson: All right, thanks.

Operator: Your next question comes from the line of Lauren Gennett.

Lauren Gennett: Hi, what must a provider show, if anything, to ask CMS for an extension of time to submit an Administrative Agreement, and if an extension is granted, do you know how long those extensions will be?

Melanie Combs-Dyer: I would like to hold that question 'til the end. Jerry Walters is the one that needs to answer that question, and he is not available right now, but we do anticipate that he will be back in the room later. Let's go on to our next question, please.

Operator: The next question comes from the line of Andrew Bratzler.

Andrew Bratzler: This is Andrew Bratzler. Could you please elaborate on the sampling process that will take place in the third and fourth level in the ALJ and DAB level claims?

Maria Ramirez: This is Maria Ramirez again, and I am not aware of any claims that have entered into the extrapolation process at the Level 3.

Melanie Combs-Dyer: I think the question is about the sampling process that will happen during the validation that the Medicare contractors will be going through. And I think we may have an FAQ on that, although I'm not seeing it right away.

Maria Ramirez: I'm sorry. Yes, I thought the question was related to the extrapolation process, not the sampling. So my understanding is that the administrative clerk will get a copy of the spreadsheets that they get from CMS and that we receive from you here at CMS and we will forward that to them. They will do — run by the system and make sure that the claims are valid and send them to the appropriate level. And then Level 3 and level 4 will do their validation, probably at a later time.

Melanie Combs-Dyer: And this is Melanie. I found the FAQ, it appears on page 13 of the most recent version, at least the way I have it printed out. It is question Number C19 and C20, "Will CMS and its contractors validate all claims on a hospital's eligible claim list of only a sample?" And number 20: "If sampling is used, how many claims will be sampled?" Was that responsive to your question Drew?

Andrew Bratzler: Can you just, please, clarify what a small, convenient sample consists of?

Melanie Combs-Dyer: I think it's going to vary by each spreadsheet. Maria, is that an accurate way to characterize it?

Maria Ramirez: Yes, thank you. I think that they're just going to pull a sample to make sure that what you're stating in your spreadsheet — that your claims are pending at either the ALJ level of the DAB level — is correct.

Andrew Bratzler: So would like a 10-percent sampling be a good guesstimate?

Maria Ramirez: I couldn't tell right off the top what percentage.

Melanie Combs-Dyer: And it would — probably would increase if during the first few that they pulled they found some errors, they may increase the number that they choose to sample.

Maria Ramirez: Correct.

Melanie Combs-Dyer: So it will vary, it will sort of be customized, spreadsheet by spreadsheet.

Andrew Bratzler: OK, thank you.

Operator: The next question comes from the line of Jodie Caplan.

Jodie Caplan: Hi, I was wondering. If a secondary insurer requests that you release information about the settlement, will you?

Mark Korpela: This is Mark Korpela. Will we here at CMS or will you as the provider?

Jodie Caplan: No, will you at CMS? So let's say Aetna or Anthem or somebody asks you to release information regarding their providers who settled, their hospital provider who settled, would you do that?

Mark Korpela: It's Mark again. We're going to have to respond to that one later. Unfortunately, we don't have the answer to that right now. It's the first time that we've been posed that question. Thank you, though.

Jodie Caplan: You're welcome.

Mark Korpela: If we can answer later on in the call, we will. If not, we're going to have to address it separately.

Jodie Caplan: OK, thank you.

Mark Korpela: Thank you.

Operator: Your next question comes from the line of Jozette Cook-White.

Jozette Cook-White: My question has already been answered, thank you.

Operator: The next question comes from the line of Laura Gray.

Laura Gray: Yes, this is Laura, I'm at Providence and I was — had a question on the new administrative adjustment or agreement sheet you posted. If we still have hospitals that are too long for it and they cut it off, what do you want us to do?

Melanie Combs-Dyer: Why don't you contact us? Go ahead and say in the email — send an email to the spreadsheet box — the place that you would normally be submitting your spreadsheet — and indicate that your name is too long to fit in the box and we will work out a separate procedure. It may be that we need you to print it out and hand write in the name of your hospital and then scan that and send it in to us. In fact, I'm looking at folks, they're telling me that's the correct process. So you don't need to ask the question. Here's your answer — print it out, hand write in your name, and then take a scan and send us that PDF.

Laura Gray: OK, thank you.

Operator: Your next question comes from the line of Dana Gould.

Dana Gould: Hi, my question has to do with the timeframe for clarifying those spreadsheets. We've already submitted our spreadsheet and I know that a timeframe has not been provided anywhere, but do you have any estimates on how long it's going to take to clarify that? I know we get paid 60 days after the agreement is agreed upon by both of us, but I've never seen anything to tell me that it's a potential timeframe on clarifying those.

Melanie Combs-Dyer: I believe we have a FAQ on that. I'm going to see if I can find it quickly. We do not have a specific timeframe. We're asking each one of our contractors if they can get back to us within 30 days — or get back to you within 30 days, but I'm not finding that Q&A right now.

Dana Gould: I just read it yesterday. I didn't see any, I read through it yesterday.

Melanie Combs-Dyer: OK, we'll see if we can't get something out there about the timeframe.

Dana Gould: OK, I appreciate that, thank you.

Melanie Combs-Dyer: Um-hum.

Operator: The next question comes from the line Karen Feeley.

Karen Feeley: Hi, this is Karen Feeley from New York Presbyterian and the lady before me just asked the same question. So thank you.

Operator: Your next question comes from the line of Karen McKenney.

Karen McKenney: Yes, hi, good afternoon. Yes, hi, good afternoon. I just had a question, and I think you said you might have to go back to, but it's regarding, how do you go about applying for an extension and are you considering granting extensions? There's just one very vague reference on the Inpatient Hospital Review portal, and I was just — that is what my question was regarding.

Jerry Walters: Priscilla, this is Jerry Walters, and I think there was a previous inquiry and I apologize …

Karen McKenney: Right.

Jerry Walters: … for not being present, but let me try to answer that for you. There is a brief Q&A on the CMS website about, you know, granting extensions. What we were considering is this, and we often find this throughout the country, that there are extenuating circumstances that occur due to fire or flooding, hurricanes, or tornados and other things that destroy records and make things difficult for a particular health care provider to provide information. This occurs throughout the nation routinely in a year. And so the concept was that if you have, unfortunately, been subjected to such a circumstance and if you could explain that to us, then we are willing to work with you.

We do not want to grant extensions universally. We're looking for those instances in which there are extenuating circumstances. And I encourage you to submit to us your request for an extension and explain what circumstances you have incurred that would offer us an opportunity to make a rational judgment about your request.

Karen McKenney: Great. And that would go to the Medicare Appeals Settlement email. Is that where that would be sent?

Jerry Walters: Yes, that's correct.

Karen McKenney: OK, great, thank you very much.

Operator: The next question comes from the line of Frank Doll.

Frank Doll: Hello, how are you? I have a question. We submitted our appeal, the Administrative Agreement, and our spreadsheet sent in a manner that was encrypted, thank you. And I guess I just want to know that you opened that — that you were able to open that encrypted file. That's what I'm wondering.

Melanie Combs-Dyer: This is Melanie. We always send back a receipt. There are actually two receipts, there's an automated receipt just saying if you made it to the mailbox – you typed in the name of the mailbox correctly. And then once we open it up and have confirmed that everything was attached and readable, you get a second receipt. So I would ask you, did you get two receipts back?

Frank Doll: No, I did not.

Melanie Combs-Dyer: OK, then something has gone wrong and I would suggest that you try again. I would also remind you that the — no information that is in the Administrative Agreement and no information that is in the spreadsheet contains protected health information, or PHI. And so you do not — you are not required to send it encrypted. If you want to send it encrypted, you certainly can, but I would encourage anyone who is trying to send it encrypted, if you do not receive back those two receipts, then you should assume that something has gone wrong and you need to send us a separate email and let us know. Uh-oh, was I — Terry, go ahead, was I saying that correctly?

Female: We were (inaudible).

Frank Doll: Well you know, I'm sorry, I didn't hear that, but I think I did get something back that said, "Delivery to these recipients or groups is complete."

Melanie Combs-Dyer: Hang on 1 second, we're going to go offline.

Frank Doll: OK.

(Crosstalk.)

Melanie Combs-Dyer: This is Melanie, I apologize for the delay. We have talked about this internally and everyone should receive one receipt back from CMS. That is the receipt back that says it made it to the mailbox. If you get that receipt back that says we received your submission to our mailbox, that automated receipt, then you're good to go unless you hear back from us otherwise. If we receive your email and we are unable to open the attachment because of the way that you have it encrypted, we will contact you and we will let you know that we are unable to open your attachment.

So if you did not receive something from us, you need to reach out and let us know. In fact, if you would like to, Frank, if you would like to give us your phone number, we would be happy to give you a call to make sure that we get yours processed correctly.

Frank Doll: Yes, that would be great, XXX-XXX-XXXX.

Melanie Combs-Dyer: Got it. Thank you very much, Frank, we'll be contacting you this afternoon.

Frank Doll: Thank you.

Operator: Your next question comes from the line of Cristina Hughes.

Cristina Hughes: Hello, thank you for taking our calls and questions today. I had one point of clarification and then a question. You referenced earlier the new FAQ number A21 about claims for which a demand letter hasn't been issued. And in your answer, you don't say yes or no. You only say that only claims that have been actually denied on or before the date are eligible. But, you know, there's a disconnect there between receiving a demand letter and receiving a denial. Because you get denials from all manner of sources, but you only get your demand letter from your MAC. So can you clarify if the demand letter is what you're seeking to consider a claim eligible for the settlement?

Melanie Combs-Dyer: Cristina, hold on for just a minute. OK, this is Melanie and if you got a review results letter from one of your contractors, that is irrelevant to this process. What is important is what you see on your remittance advice or a demand letter. Those are the two things that are most important. Generally, for a prepayment review, it shows up on your remittance advice. If you see it in postpay review, it will be a demand letter and maybe something also on your remittance advice.

Cristina Hughes: OK, so thank you for clarifying that. And then, with respect to my question, you mentioned earlier that individual claims that were part of an extrapolation would potentially be eligible for the settlement. But what about an extrapolation that is based solely on patient status claim denials? Would that whole extrapolation be eligible for participation in the settlement?

Melanie Combs-Dyer: So this is Melanie, and if there were, I'm making up this number, 10 sample claims that were reviewed by, say the ZPIC, and all of them were patient status and all of them met all seven criteria – it was the right date and everything else met the criteria — then all 10 of those claims would be eligible for settlement. You should include them on your spreadsheet and we'll validate them and you'll get the 68 percent for them. How that impacts the extrapolated amount, you would need to contact the ZPIC and have a conversation with them.

Cristina Hughes: OK, but as you've mentioned in the past, those claims remain technically denied in the system, correct?

Melanie Combs-Dyer: That is correct, they do remain denied in the system.

Cristina Hughes: So it's entirely likely that the ZPIC will say, well, they're still denied, so we're not going to change your extrapolation amount?

Melanie Combs-Dyer: You would have to have that conversation with them.

Cristina Hughes: OK, thank you very much.

Melanie Combs-Dyer: You're welcome. And I would like to go back, if I could, just for a minute.

Diane Maupai: Next question please.

Operator: The next question comes from the line of Cathy Doran.

Cathy Doran: Hi, I — unfortunately I still have some questions about the Part B billing. It's my understanding that the claims have to be in the appeal or eligible for the appeal, correct?

Maria Ramirez: Correct.

Cathy Doran: OK. Rebilling rules stipulate that once the claim has been withdrawn from the appeals process, it's no longer eligible for appeal and once the hospital files for Part B payment, it's no longer eligible for appeal. So according to slide number 15, if you have withdrawn and received a dismissal note but not received your Part B payment, then you have to opt for the settlement. But if I have withdrawn and received a dismissal notice, I'm not eligible for appeal. So that doesn't meet the appeal requirement.

Maria Ramirez: So if you submitted a request to withdraw your Part A claim …

Cathy Doran: Yes.

Maria Ramirez: … and have not received the dismissal letter,

Cathy Doran: OK.

Maria Ramirez: … if you have already received the dismissal letter but have not submitted the Part B claim or …

Cathy Doran: Um-hum, now that makes it not eligible for appeal. If I have a dismissal notice, I am out of the appeal process.

Maria Ramirez: Well dismissal notice still gives you the right to appeal to the next level.

Cathy Doran: I'm not aware of that.

Maria Ramirez: Yes, you should have appeal rights to the next level.

Cathy Doran: OK, because our rebilling, according to let's see, MMA277, once a Part B claim under rebilling — well once we file the claim, …

Maria Ramirez: Once you file the claim …

Cathy Doran: …the parties are no longer able to request further appeal.

Maria Ramirez: So that is the difference, correct. You asked a different question.

Cathy Doran: OK, so once I filed the Part B, it's no longer eligible for appeal so, therefore, even if I have not received payment, it's not eligible for the settlement.

Melanie Combs-Dyer: This is Melanie and I'm not sure that — are you talking about scenario 3 on slide 15?

Cathy Doran: Yes, yes.

Melanie Combs-Dyer: Those are still eligible for appeal, right Maria? And eligible for settlement.

Maria Ramirez: That is correct, yes.

Melanie Combs-Dyer: And eligible for settlement.

Cathy Doran: OK.

Maria Ramirez: Yes, so if you have already — yes, so if you have received a dismissal notice and you submitted your Part B claim but have not yet received payment from the MAC, that claim is eligible for this settlement.

Cathy Doran: OK, OK. According to MLN Matters number MMA277, "Once a Part B claim under the ruling is submitted, parties are no longer able to request further appeals."

Maria Ramirez: But in this case …

Cathy Doran: So it's not — I'm not able to appeal it, but I have to – but my payment hasn't come in and so, therefore, I have to accept the settlement.

Melanie Combs-Dyer: Hang on for 1 second.

Maria Ramirez: So that dismissal request can still be vacated by the next level of appeals. So technically, it's appealable.

Cathy Doran: So even though my rebilling rule says I cannot appeal any further once I've filed for Part B, I cannot appeal any further. I have to take the settlement if the payment — if I've got some kind of stall at my MAC. I cannot — I have to accept the settlement?

Maria Ramirez: So the settlement process is a voluntary process.

Cathy Doran: No, I'm talking about that it has to be, that particular claim has to be included in the settlement?

Maria Ramirez: Yes, yes, yes. If you have not received payment and you've already submitted your Part B claim, that claim needs to be included in the settlement.

Cathy Doran: OK, so you're telling me that the Part B rules are not applying? The rebilling rules are not applying?

Maria Ramirez: Well, because you've already kind of complied with the Part B — or the rebilling rules, you withdrew your request, you submitted your Part B claim. And so for payment purposes, we are going to include those in the settlement process.

Melanie Combs-Dyer: So long as it's still within the timeframe to be vacated by the appeal adjudicator. If these are 3 years old, that doesn't apply.

Maria Ramirez: Right.

Melanie Combs-Dyer: But if it's still within the timeframe to be vacated by the appeal adjudicator, it's still, it still …

Maria Ramirez: Eligible.

Melanie Combs-Dyer: …It still can be eligible.

Cathy Doran: So if my appeal deadline was — say I submitted my request on October 24th and my appeal deadline, or my Part B filing deadline has already passed, then I'm no longer eligible for appeal and that would, even though I haven't received my payment, I don't have to submit that to settlement?

Melanie Combs-Dyer: I'm sorry, can you say that scenario again?

Maria Ramirez: One more time, yes. Thank you.

Melanie Combs-Dyer: October 24th is when you submitted your …

Cathy Doran: Right.

Melanie Combs-Dyer: settlement request that you have …

Cathy Doran: I have filed for Part B payment with those deadlines for rebilling, say October 15th, and I'm filing for my request for settlement on the 24th, but my deadline is October 15th for the rebilling — those are not eligible for settlement?

Melanie Combs-Dyer: Why don't you send that scenario to us — to the FAQ mailbox and we will try to walk it through with you and then post an FAQ so that everyone can benefit from hearing your example?

Cathy Doran: OK, I will do that.

Maria Ramirez: Thank you.

Melanie Combs-Dyer: Thank you.

Cathy Doran: Thank you.

Operator: Your next question comes from the line of Cathleen Mathey.

Cathleen Mathey: Yes, can you hear me?

Melanie Combs-Dyer: Yes, Cathleen, go ahead.

Cathleen Mathey: I think you've answered this, but it's my understanding that we do not need to encrypt the files when we send them because the only identifiable – there's no identifiable data. It's simply claim numbers and dates of service, is that correct?

Melanie Combs-Dyer: It is correct that when you are submitting your initial submission to us that contains the Administrative Agreement and the spreadsheet, you do not need to encrypt it.

We are currently working on the procedures for down the road if there are disputes that cannot – disagreements claims that cannot get resolved and you need to submit additional paperwork, for example, maybe appeal dismissal letters or other things like that, it may be that we need you to follow a different process. And we are working on what that process would be to make sure that you can submit that kind of information to us in a secure manner, because that information will contain PHI, protected health information. But for the initial submission — for the Administrative Agreement and for the spreadsheet, it does not contain PHI. You do not need to encrypt it.

Cathleen Mathey: OK, thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next question comes from the line of Teresa Sweatman.

Margie McGee: Hello, this is Margie McGee calling from Southwest Mississippi Regional Medical Center. In reference to page 14, indicating the provider should not seek additional payment from Medicare beneficiaries or collect any deductible coinsurance amounts; however, you qualify that by saying that they may retain amounts already paid. Now you're — I'm a little bit concerned with your using the word beneficiary. So my question is, if you have received your deductible and our coinsurance from a payer because we don't consider the claim denied until we have gone all the way through the ALJ and received the denial, so we don't consider it denial. So we, therefore, retain the deductible and copay that we've already received. Are we in a position to be — and made reference to that statement that you may retain amounts already paid if, in fact, we do the settlement and we retained the deductible and copay that we have already received, even though it comes from a third party payer or even Medicaid?

Mark Korpela: This is Mark Korpela. The FAQs that are out there and this slide also refer specifically to a Medicare beneficiary. If we're talking about another payer, that's where we gave a somewhat different answer that we would say normal practices by that payer would apply. Now when you say payer, that could mean many, many things, including a person, another insurance company. The FAQs that are out there where we talk about beneficiary say that you will not seek additional payment from them and you may retain the amounts already paid. That doesn't necessarily apply to, like, a secondary insurance company, if that's what you're talking about. What we're saying there …

Margie McGee: My question is not pursuing payment of the deductible and copay. I'm not trying to request or submit a request for payment to anyone after having settled; however, if I have already received the deductible and copay because I did not consider that service denied until such fact, such time as it is truly denied by the ALJ. I've gone all the way to the limit. So, therefore, my thought is I've got it. You say I can retain it, and my question is, can I count on that statement if one of those third-party payers, be it Blue Cross, be it Aetna, be it Medicaid, may I — they are secondary payments that I've already received payment from — may I retain that deductible and coinsurance for those patients?

Mark Korpela: So earlier in the question you asked if you could rely on that statement. The answer is, no. We're specifically referring to the beneficiaries. Because this is a secondary payer, what we are saying is the claim is denied and the secondary payer may treat that however they want. You may be treating it as a paid claim, but we view it as a denied claim that you're receiving a settlement payment on. Therefore, whatever that secondary payer, Blue Cross or whoever you were referring to, you follow the normal process that they would on a denied claim. We are not going to tell you whether you

can keep that or you have to return that because that's another insurance company involved that we cannot instruct you what to do with them.

Margie McGee: Well, that doesn't seem fair that you can keep the patients' deductible and copay because you're saying that's denied also. So it seems like it's double standards. But I guess, I'm really trying to find out if am I able to retain or do I need to voluntarily refund it because we have reached the settlement amount? Or do I just — if I'm requested by that payer to refund that amount, then I gather you're saying that we probably should. But if I'm not requested — because you wouldn't answer the question about whether you're going to share that settlement information. I don't want to be in a position where I am not ethical; however, the fact is that it is a deductible and copay that comes into play with what that reimbursable amount is. And so — and you're saying that we can retain it? Do I — am I obligated as a provider ethically to go ahead and refund that if we enter into the settlement? Refund it to the third party or secondary payers …

Jerry Walters: Hi, this is …

Margie McGee: … and yet not refund it to the patient?

Jerry Walters: Hi, this is Jerry Walters and let me try to just touch on that a little bit. We understand the question and the complexity that, you know, is associated with it. And one, I completely understand and admire your concern about, you know, being ethically responsible with this. I think the struggle that we're having here is a little bit of CMS itself cannot dictate to other insurers how it behaves as an entity in the health care industry and how it coordinates and works with others regarding these types of resolutions.

These claims, as Mark had described, will remain in the CMS system as denied claims. So there will not be a reprocessing of a claim, there will not be a crossover of a claim going to a third party insurer. So we cannot direct others how to operate under their arrangements and agreements with health care providers and others. I understand why you're asking the question. We're not in a position to be able to instruct others on how to conduct their operations in business.

Then you asked the question, as was earlier asked, and I think it's something that we need to consult with our attorneys a little bit more about, is are we going to release this information if people ask? These are legal agreements and there are certain constraints around legal agreements that when they are available to the public and how the public may request such agreements. I can't answer the legality of that at this point, but I'll be happy to research that with my attorneys. We'll try to provide a Q&A to that matter. And I hope that helps you understand where we stand.

Margie McGee: Just one point because you there indicated that you can't instruct those other payers. Of course, one of those payers is a CMS payer, its Medicaid. So I guess I need to know because there have been some issue where we have held a Medicaid payment because we haven't received a true denial as yet because they didn't get to the ALJ. But I am also concerned if you want to refer this to your attorneys, you can dictate to us or to the patient for that matter that they don't have a right to get their deductible and copay back that they paid yet the other payer can. It seems just to me, it needs to be all or none.

Melanie Combs-Dyer: Margie.

Jerry Walters: Yes, and I see your point. And I guess, perhaps, what you're talking about is a dual-eligible beneficiary. But let's remember one thing, once a Medicare claim is denied for purposes, in generally — in a postpayment review, there is an obligation to return to a beneficiary copay, coinsurance that has been paid associated with that practice. And a hospital, for example, would then have reimbursed already the beneficiary. That's the normal course of business. And so I think perhaps taking enough time on this, we will do some research. We'll try to get some Q&As up on the website for you to help you better understand and choose how to proceed.

Diane Maupai: Thank you Margie.

Operator: Your next question comes from the line of Charles Poggioli.

Charles Poggioli: Thank you, but you've already answered the question. It related the October 31st deadline. We're struggling to meet that, that's all. I'll wait — I'll go online and submit the request. Thank you.

Operator: Your next question comes from the line of Walter Finney.

Walter Finney: Yes, and asking a question on that same line, are there any penalties or negative issues if we decide to put off our decision?

Melanie Combs-Dyer: If you decide to put off your decision about whether or not to participate in the settlement?

Walter Finney: Yes, if we ask for an extension.

Melanie Combs-Dyer: Jerry, do you want to tackle that one?

Jerry Walters: Yes, I will do my best. There is no associated penalty with that if we find and agree that you have some extenuating circumstances and that you need a little bit more time, we will remain in complete agreement with the current Administrative Agreement as it's drafted.

Walter Finney: And could you just give me one example of what you might accept as a reason?

Jerry Walters: As I was trying to say earlier, is it's obviously events of, for example, of flooding or tornados where service, excuse me — records and other things have been damaged due to the damage to a facility, for example, would be an explanation. If it is lost or misplaced documents, that is an entirely different story. If you believe that you have a rational extenuating circumstances that you would like to explain to us, we'll be happy to consider it.

Melanie Combs-Dyer: This is Melanie. I will also tell you that we have a definition of disaster in our Program Integrity Manual. I will pull out that language and put it into an FAQ to give you an example. To let you know how long ago it was that we wrote that language, it talks about the kinds of things that Jerry just mentioned — floods, tornado, it also mentioned the Anthrax scare. Perhaps in this day and age it would be if your hospital was bombarded with Ebola patients and you just can't get to your Settlement Agreement in time, let us know and we would consider that. So I'll put up that definition of disaster so that folks know what we're talking about.

Walter Finney: Thank you.

Operator: The next question comes from the line of Marsha Mitnik.

Marsha Mitnik: Hi, my question is we have a few cases that are scheduled for ALJ hearings and we also have some cases that have had their ALJ hearing but we don't have a result yet. Should I put those cases on my list?

Maria Ramirez: Right, this is Maria Ramirez, and yes, you should be including all those claims on your spreadsheets. As I said, excuse me, what's going to happen is that we will disseminate that information to the Office of Medicare Hearings and Appeals, and as soon as they receive that they will pend those claims and so your decision will not be issued and your hearings will most likely be postponed until a settlement is finalized.

Marsha Mitnik: We had two cases that were actually scheduled between now and October 31st, so we've already approached those judges and asked them to delay them till afterwards.

Maria Ramirez: OK.

Diane Maupai: Thank you.

Marsha Mitnik: OK, thank you.

Operator: Your next question comes from the line of Cathy Navarrete.

Cathy Navarrete: Hi, this is Cathy Navarrete. I'm calling from Barton Memorial Hospital. I think I found the answer on page 20 of the FAQ. My question was, what was the impact to the Medicare bad debt reporting. So I'll just refer to that.

Melanie Combs-Dyer: Thank you Cathy.

Operator: Your next question comes from the line of Ami Carvotta.

Ami Carvotta: Hi, my name is Ami Carvotta, I'm calling form Concord Hospital. I'm wondering if it's past the 60 day timeframe for appealing to the ALJ and we've submitted a request but OMHA hasn't given it an ALJ appeal number, I'm wondering what will happen. Basically if we have no proof that we sent in an appeal, will those be eligible?

Maria Ramirez: Yes, those would be eligible. And so what you want to do is include the QIC appeal number on the spreadsheet and then, if necessary, you will be asked to provide evidence that you submitted that request to the ALJ level of appeal. But otherwise including the QIC appeal number and knowing — we will know that the claim was eligible and you can maybe, I don't know if there's a space on the spreadsheet to let you know that they were appeals to the next level, that would probably be helpful.

Ami Carvotta: Great, thank you.

Maria Ramirez: Sure.

Operator: Your next question comes from the line of Joseph Fredricks.

Joseph Fredricks: Good afternoon, this is Joe Fredricks calling from Executive Health Resources. I just have two questions I wanted to ask real quick. I know that we originally were — it was communicated that we were able to — or not able to submit coding cases. However, if we have dual denials — medical necessity and coding — that are in the appeal process, would they be eligible for the settlement?

Melanie Combs-Dyer: This is Melanie and the answer is, yes. I believe we have put out an FAQ recently about that. I'll look for it, see if I can find it, and mention that in a minute. But yes, if it is — if it was denied for coding reason and for patient status reasons, then yes, that would be eligible.

Joseph Fredricks: Wonderful. And the second question is just to, I guess a go off the previous question. If a case is submitted to the OMHA and it's past the deadline and doesn't fall within the 5-day mailing presumption, these cases would still be eligible for the settlement as well?

Maria Ramirez: Can you clarify that please?

Joseph Fredricks: We have 60 days to submit the hearing request to the ALJ. If they are not in receipt of that request within 65 days with the 5-day mailing presumption, say it gets there on the 67th day, would this case still be eligible if the OMHA has not acknowledge receipt of the request?

Maria Ramirez: So if you submitted your request at the ALJ level and it's timely, OMHA will validate that later. You can definitely include those on your spreadsheet and, as I stated, include the QIC appeal number and make a statement or make a note letting us know that you submitted your request for appeal to the ALJ level.

Melanie Combs-Dyer: Thank you Maria. And this is Melanie. On the question that was asked earlier about it was denied for two reasons — is it eligible? The answer appears in questions number B like boy 19, on my printout that's on page 8. B19 says, "Is the case eligible for settlement if it started as a DRG coding denial but during the appeal review it was denied for incorrect patient status?

And the answer reads, "Yes, these are eligible for settlement assuming all other claim eligibility criteria are met." So Joseph from EHR, I hope that answers your question.

Operator: Your next question comes from the line of Jan Dunn.

Jan Dunn: Yes, one of my questions was already answered, but I have a technical question. On the spreadsheet where it has a date column for when you submitted the claim, it gives a drop-down option, which actually gives you the option of the level. It will not let you place in numbers for the date. Is it OK to insert a column so that the date can be there?

Melanie Combs-Dyer: Jan, you are working from an old version of the spreadsheet, I would encourage you to go back out to our website and pull down the correct version of the spreadsheet. It was updated about 2 or 3 weeks ago and you will be able to do what you need to do in that field now.

Jan Dunn: Thank you.

Melanie Combs-Dyer: You're welcome.

Operator: The next question comes from the line of Carl Ferebee.

Carl Ferebee: Yes, my question is, are you going to address the questions that were sent in doing registration process today or, if not, how are you going to address those?

Melanie Combs-Dyer: Yes.

Carl Ferebee: That's one. It's a two-part question. And while I'm in that question mode, if we are still not 100 percent — not clear today, is there a direct contact from you all that may be able to walk us through a couple of scenarios?

Melanie Combs-Dyer: This is Melanie and we looked over all the questions that you guys submitted. We identified the most common questions and we either addressed them — Mark Korpela addressed them of the MSP question and the rebilling questions by Maria. If we didn't feel like there were a lot of questions on that topic, we put out FAQs. We will continue to put out more FAQs. So if you don't feel like your question has been answered during our presentation or the FAQs that have already been put out, we would love to hear your question now. What is your question Carl?

Carl Ferebee: Well, I'm still not 100 percent clear on if once we have billed the — and it sounded like if we bill the inpatient and it was a status issue and we rebill that and we've not received any type of response, then what? That's one part of it.

Melanie Combs-Dyer: So Carl, I would encourage you to look at the slides that we talked about today on page 10 and page 11. Those are the eligible claim criteria and you need to take each claim and go through all seven of those and see if each of the seven criteria are met. For example, it meets criteria number three if it's patient status. Was the date of admission prior to 10/01? Did you file a timely appeal? Is it still in the appeal process? And have you not received Part B payment? If you can check off each one of those, then, yes, you should include the claim on your spreadsheet.

Carl Ferebee: OK, and then in that same question, you are going to compare our list to your list? Is there such a list out there that you can actually send us prior to — that you may have on hand?

Melanie Combs-Dyer: Carl, let us get back to you on that. We certainly would not have a full and complete list. We would be relying on you to pull together a full and complete list, but we will certainly look into whether or not we may be able to at least pull a partial list for you.

Carl Ferebee: All right, do you have my information?

Melanie Combs-Dyer: We will put out an FAQ explaining what the process would be to request that if we feel like we are able to put together a partial list and send to you. So watch the FAQs over the next few days.

Carl Ferebee: OK, thank you.

Diane Maupai: This is Diane; I just want to let everyone know we have time for one more question.

Operator: And the final question will come from the line of Melissa Duhn.

Cathy Shmuck: Yes, this is Cathy Shmuck from Benefis Health System. How will this affect a SNF claim with a 3-day qualifying stay, if the claims are denied?

Melanie Combs-Dyer: Jerry, do you want to answer the question about the SNF? Is it — let me — Melissa, is your question, it was a 3-day stay, it's now been denied, you want to know what the impact is on the SNF claim that came after that 3-day stay that's now been denied, is that your question?

Cathy Shmuck: That's it.

Melanie Combs-Dyer: Jerry, do you know the answer to that question? It sounds like we may not have the answer to that here in the room. I believe though that they do remain denied in the system, but let us check on that and we will put out an FAQ Melissa.

Jerry Walters: Yes, thank you Melanie. I think that's the best idea. We have had some conversations with our policy experts in this area. We do understand the impact of the denial based on the 3-day stay, and I think that we can give you an answer.

Cathy Shmuck: All right, thank you.

Jerry Walters: Um-hum.

Additional Information

Diane Maupai: All right this is Diane. Unfortunately, that's all the time we have for questions today. If you look at slide 21, resources, the first bullet, you'll find the link to the website that contains the FAQs. And from the questions we've gotten today, it sounds like you've all have already bookmarked that and checking it often, so that's great. You'll also see a third bullet, which is the email address for submitting any further questions that you might have.

An audio recording and the written transcript to today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 23 of the presentation you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects Call experience.

My name is Diane Maupai. I'd like to thank Melanie, Maria, Mark for presenting today and Jerry for answering questions. And thank you all for participating in today's MLN Connects Call. Have a great day everyone.

Operator: This concludes today's call.

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