MLN Connects™

National Provider Call

Hospital Appeals Settlement

October 9, 2014

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Presenters

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Agenda

I. Background

II. Rebilling

III. Other Insurance Payment

IV. Settlement Payment: Remittance Advice

V. Helpful Hints

VI. 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:
  - — Part B Rebilling: CMS Ruling 1455-R (published in March 2013) also known as the "A/B Rebilling Ruling" clarified how hospitals can rebill services as Part B
  - — Final Rule 1599 (published in August 2013), also known as the "2-Midnight Rule", addressed rebilled Part B services and clarified how Medicare contractors review inpatient hospital and critical access hospital (CAH) admissions for payment purposes

Proposed Settlement

- To more quickly reduce the volume of ***Current*** appeals, on August 29, 2014, CMS announced a new settlement opportunity
- 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

1. Denied by a MAC, RAC, CERT, OIG, or ZPIC
2. For Fee-for-Service Medicare
3. Denied based on “patient status”
4. Date of Admission prior to 10/1/2013
5. The hospital timely appealed the denial

Proposed Settlement: Eligible Claims

6. As of the date the hospital submitted the initial agreement to CMS, the appeal was still pending or the hospital had not yet exhausted its appeal rights

7. The hospital did not receive payment for the service as a Part B claim

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 validate 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: 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

Rebilling Scenarios Where Claims ARE Eligible* for Settlement

- Part A claims are eligible if the provider has not received Part B payment as of the date the provider submits the initial settlement request. Thus, Part A claims are eligible if:

- Examples:

1. The provider has requested to withdraw its Part A claim appeal but has not received a dismissal letter

2. The provider has received a dismissal notice, but has not submitted a Part B claim, and 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)

3. The provider has received a dismissal notice and submitted a Part B claim, but has not received payment from the MAC

(*Assuming all other eligibility requirements are met)

Rebilling Scenarios Where Claims ARE NOT Eligible for Settlement

- Following denial of Part A claim, the provider submits a Part B claim and receives payment

- Following dismissal of Part A claim appeal, the provider submits a Part B claim and receives payment

Other Insurance Payment

- The claims will remain as denied in CMS systems
- CMS expects that other payers, including secondary payers will continue to follow their normal processes for addressing claims denied by Medicare

Settlement Payment: Remittance Advice

- Prepayment claim denial settlement payment
  - Reported on the "Settlement Payments" line in the "Summary" section of the remittance
- Postpayment claim denial settlement payment
  - Reported on the "Refunds" line in the "Summary" section of the remittance

Helpful Hints

1. Send to MedicareAppealsSettlement@cms.hhs.gov a single email (per Provider Number) that contains:
   - subject line: *Request for Settlement Agreement from* [insert provider name]([insert 6 digit provider number]).
     - example: "Request for Settlement Agreement from General Hospital (123456)"

2. Single, signed Administrative Agreement in pdf format *(file name: PROVIDER NAME--6 DIGIT PROVIDER NUMBER--ROUND ONE.PDF)*
   - *Agreement cannot be altered in any way*
   - *Name of Hospital must be readable*

3. Single, completed excel spreadsheet (e.g. xls format) *(file name: PROVIDER NAME--6 DIGIT PROVIDER NUMBER--ROUND ONE.XLS)*

Helpful Hints

4. Spreadsheet must be completed in its entirety (Provider Claims Worksheet)
   - Data Dictionary is a reference tool
   - Header/Provider level data included
   - No additional fields/columns

5. DCN ***at least*** 14 characters (Column B)
   - On remit following the adjustment
   - DCNs less than 14 characters will be returned

6. Appeal Numbers (Column F)
   - Last known (from QIC or ALJ)
     - Format: 1-1234567890
   - Last known (from DAB)
     - Format: M-12-132, M-13-3499, M-14-1

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

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- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call.

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- For more information about the MLN Connects National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

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