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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Hospital Appeals Settlement Update 2
MLN Connects National Provider Call
Moderator: Diane Maupai
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1 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in 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 today's conference call over to Diane Maupai. Thank you, you may begin.

Announcements and Introduction

Diane Maupai: Well thank you, and hello everyone and thanks for joining us today. This is Diane Maupai from the Provider Communications Group at CMS in Baltimore. I'll be serving as your moderator today. Welcome to the third National Provider Call in the series about 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 settlement CMS has offered to acute care hospitals and critical access hospitals for resolving appeals of patient 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 have 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 web page, select National Provider Calls and Events, then select the October 21st 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. And last, for this call registrants were given the opportunity to submit questions, and we thank everyone who did so. We will address many of those questions during today's presentation, and we've also posted Hospital Settlement FAQs on the Inpatient Hospital Reviews web page. And I'll be giving you the link to that a little bit later.

So at this time let's move to slide 4, and I will introduce our CMS speakers. From the Office of Financial Management, we have Jerry Walters, who's a Senior Advisor to the Chief Financial Advisor; Melanie Combs-Dyer, Director of the Provider Compliance Group; and from the Center for Medicare, we have Maria Ramirez, who is the Director of the Division of Appeals Operations.

So now I'm going to move to slide 5, the agenda. Jerry is going to start us off with some introductory remarks. Melanie then will provide some background, talk about the Potentials List and the validation process, and Maria will cover rebilling. We will then open the line for your questions. And with that, I'll turn the call over to Jerry.

Presentation

Jerry Walters: Well thank you, Diane, and may I welcome everyone to today's call. I think it's important and we welcome your participation today. Obviously, we're getting very close to a deadline that CMS has established for requests to participate in this appeals resolution process and, again, that will be October 31st of 2014.

So I'd like to begin by trying to dispel some myths quickly here. We have established throughout the Health and Human Services Department and the Appellate Forums the dedicated resources that were necessary to just work on this process. It is not intended to impede the rest of the appeals processes that may be proceeding. And so I think that others may have concern or question about that. In fact, as many of you know, our purpose is to resolve many appeals that perhaps are impeding and slowing the appellate process throughout the entire appeals steps.

I wanted to share, also, with you today just to – for transparency sake, let me share some information with you. We have about — a request for about 88,000 appeals. We've received requests involving 88,000 appeals for consideration and the resolution. It gives you an idea of what CMS has been receiving. I wanted to share with you also, payments have begun. And lastly, there's a large amount of return information to hospitals who are decision whether to consider accepting each claim values appeal amount and the gross value that they would receive for all of those appeals and then they would be resolved and withdrawn. So those are considerable amounts still remaining with hospitals to provide us their response to that.

So as you might imagine, there's a lot of coordination going on — a significant amount. And so it's not a perfect process as we try to work with every Medicare contractor, every appeals forum, and work with the CMS staff that are dedicated here to resolve these. It's not perfect. We got a hiccup here or there, but in general, the process is working. We are getting appeals in, we're getting return amounts to the hospitals for decision, and we've begun making payments.

So there's an opportunity here that I want to make everyone aware of, and this is what we're going to discuss in a minute about Potentials Lists. I think there's an opportunity, if you were on the fence or unable to prepare information necessary to submit a request to be included in the appeals resolution process. If you submit to us in a request for a Potentials List, which is a list that we will provide, and Melanie will go over this in a minute, we will accept that request or a list of potential with claims that could be considered as an intent to participate. So what it does is it gets you in the queue and it gives you an opportunity to at least get in line and be in place. And we would like those, obviously, to come to us no later than October 31st of 2014.

And with that I'll turn it over to Melanie, and she can begin with a little bit of background and discuss this Potentials List.

Background

Melanie Combs-Dyer: Thank you, this is Melanie Combs-Dyer. I'm the Director of the Provider Compliance Group. I'm on page 6. Just to refresh everyone's memory, an eligible provider for this settlement process is an acute care hospital or a critical access hospital.

Slide 7 describes the eligible claim criteria, and there's one clarification that I want to point out on this slide. Criteria number 1 says that the claim was denied by a MAC, a RAC, CERT, ZPIC, or QIO. A number of you have submitted questions regarding the QIO process, and I just want to make sure that folks understand. It doesn't matter who made the claim denial — the MAC, the RAC, CERT, QIO, ZPIC — and it doesn't matter if the claim denial was made on a prepayment or postpayment basis. But for reviews that were conducted by a QIO, in order to be considered a claim denial, there must be a demand letter that was sent by the MAC to start the process of recouping the payment. And just a reminder, that's just the first criteria. All the other criteria have to be met as well.

So, for example, we've gotten a question about, can we include claims for which we have not yet received the demand letter but which we know is forthcoming?

And the answer is that only claims that are actually denied on or before the date you submit the initial Administrative Agreement to CMS mailbox and that meet all the other criteria listed as eligible claims criteria can be included in the settlement. For reviews that are conducted by a QIO, remember that in order to be considered a claim denial, there has to be a demand letter sent by the MAC to start the process of recouping the payment along with all the other criteria that have to be met.

And we have gotten a question from someone who says that their QIO sent them an admission denial, is that eligible for settlement?

And we would again remind you that only claim denials are eligible for settlement so long as all the other requirements are met. And a claim denial occurs when the MAC issues a demand letter for the case that was reviewed by the QIO. So if you have something from the QIO, and it says that it's a denial of something and you're not sure if that's a claim denial or not, look to see whether or not you've gotten a demand letter from the MAC. If you have gotten a demand letter from the MAC and all the other criteria are met, you're in the appeals process if patient status, the date of admission is prior to 10/1, then that can be included in the settlement.

Let's move on to slide 8. This, again, nothing new on this slide, although we have bolded October 31st, 2014. A number of you asked last time if that date was going to change, are we extending the due date?

The answer is no. The due date for submitting your initial settlement request to CMS remains October 31st, 2014. The URL is listed at the bottom if you want more information. And again, at the top of the page is the email address to which you need to send your settlement request on or before October 31st, 2014.

The Potentials List

Slide 9 describes the Potentials List. This is what Jerry mentioned just a few minutes ago as a way to either ask CMS to send you a list of potentially eligible claims that you can use to start your request process or even if you're, like Jerry said, sitting on the fence or you haven't decided and you want to just reserve your spot in line, you can submit a Potentials List. The Potentials List process — how you go about requesting it — is described here on slide 9. Again, you send an email to the normal mailbox, that's MedicareAppealsSettlement@cms.hhs.gov, and in the subject line you say it's a Request for Potentials List from — and you put your provider name and your provider number. And then in the body of the email, you need to list each NPI that's associated with that provider number.

Now, I want to point out that a Potentials List is just that. It's a Potentials List and it will not include any claims that are still in the appeals process at lower levels of appeal, like at the MAC. And it may include claims that are no longer eligible because one of the other criteria has not been met. For example, perhaps – you would get something that's included on your Potentials List but you've received Part B payment, so you would have to take that one off. Again, to request a Potentials List, send an email to the mailbox, subject line is, "Request for Potentials List," from your name, your number. And in the body of the email, list each NPI associated with the provider number.

The Validation Process

Moving on to slide 10, the validation process. There have been some questions about exactly what a provider is supposed to do when they receive that notification from the Medicare Administrative Contractor that has a list of agreement claims. Most of the time the MAC will include both the list of agreements and the list of disagreements, and it's important that the hospital reply all to that email. If you reply all to that email, you will be responding to both the MAC and to CMS and you will let us know whether you want to proceed with the process or you want to abandon the process. If you want to …

Female: Hello?

Melanie Combs-Dyer … if you want — if you want to proceed, that email will then trigger us to send your payments for your Round 1 agreement and let us know that you will be sending in a Round 2 Administrative Agreement for the claims that had been in the disagree process. It will also trigger the appeals entities to dismiss the appeals that were listed on that agreement list.

Slide 11 continues on with the validation process and Round 2. Again, when you get that disagree list, you have to sign another Administrative Agreement. You have to put together that new list of eligible claims, and you need to put in the comment box for each disagree if you think that there — if you disagree with the disagree list, you need to let us know why. It's possible, for example, that something has been added to the list that you don't think should be added to the list. For example, something gets added to the list by the MAC and you know that you've received Part B payment. So you would just put in the comment box that you've received Part B payment and that's why that one needs to come off of the list. You will submit your new agreement and your new eligible claims spreadsheet to the normal appeals settlement mailbox and you will do everything the same, except that the name is changed to Round 2.

That brings us to the end of this slide and so I'm going to turn it over to Diane to do some polling.

Keypad Polling

Diane Maupai: All right, 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 that there will 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'd now like to turn the call back over to Diane Maupai.

Presentation continued

Diane Maupai: Thank you, and I'm going to in turn — turn the call over to Maria.

Rebilling Scenarios

Maria Ramirez: Thank you Diane. I am going to talk about rebilling scenarios and which claims we believe are eligible for a settlement. Again, assuming that all other criteria is met, we have the following examples that we believe will be eligible for settlement:

- The provider requested to withdraw a Part A claim but has not received the dismissal letter;
- The provider received the dismissal notice but has not submitted a Part B claim — and this is the clarification from the last call — and there is still time for the dismissal to be reviewed at the next level or for the claim to be — or the decision to be vacated by the next level appeal adjudicator;
- The provider has received the dismissal notice and submitted the Part B claim but has not yet received payment from the MAC.

The following are scenarios where we don't believe are eligible for settlement:

- Following the denial of a Part A claim, the provider submits a Part B claim and has already received payment, and
- Following the dismissal of a Part A claim, the provider has submitted the Part B claim and has already received payment.

And with that, I'll turn it back to Melanie.

Question-and-Answer Session

Melanie Combs-Dyer: Thank you very much, and I think we are ready to open the line for questions.

Diane Maupai: All right. So that's right. Before we begin that though, I'd like to remind everyone that this call is being recorded and transcribed. So before asking your question, please state your name and the name of your organization. And in an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you'd like to ask a followup question or have more than one question, please press star 1 to get back into the queue and we'll address additional questions as time permits.

So 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 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 Mary Harless.

Mary Harless: Hi, my name is Mary Harless. I'm with the University of Kansas Hospital. And I do have a question about the rebilling scenarios, which I don't believe has been addressed by the slide that we just looked at. We have some that we have not necessarily withdrawn but we did not pursue to the next level of appeal and it is beyond timely filing for the next level of appeal, but we are still within timely filing for the A to be rebilled. So should we include those on the spreadsheet or not?

Melanie Combs-Dyer: This is Melanie, and let me make sure that I'm understanding, and I'll just tell you which slide I'm going to be looking at. I'm going to open up to slide 7 so I can see all of the eligible claim criteria and I'm going to be looking particularly at number 6, which says that, "As of the date that the hospital submitted the initial agreement to CMS, the appeal was still pending or the hospital had not yet exhausted its appeal rights." Now in the scenario that you just described, am I correct that criteria number 6 is not met?

Mary Harless: That would be correct.

Melanie Combs-Dyer: If criteria 6 is not met, you should not include the claim on your eligible claim spreadsheet.

Mary Harless: Thank you for verifying.

Melanie Combs-Dyer: You're welcome.

Operator: The next question comes from the line of Melissa Duhn.

Melissa Duhn: Yes, thank you. We still have not got the answer to how this is going to affect skilled nursing billing. If the claim is going to look denied in the system, how is that going to affect the 3-day qualifying stay for nursing home?

Melanie Combs-Dyer: This is Melanie and the claim will remain – will remain denied in the system, and I don't know what impact that will have on your skilled nursing facility still.

Melissa Duhn: OK. So is that going to be answered any time soon because we have our own skilled nursing facility and this could impact us financially? If the …

Melanie Combs-Dyer: No, I don't – I don't believe that that question will be answered anywhere in the settlement process. You can certainly submit a question to CMS in general about how a denied inpatient hospital claim — how that impacts the SNF claim, but I – it will not be the settlement team that will be answering that question.

Melissa Duhn: Yes, I have actually sent that question twice now and I've never received an answer. Do you know who I would send it directly to by chance?

Melanie Combs-Dyer: I do not. Jerry, do you know who in CMS answers SNF questions?

Jerry Walters: Well, I think that — hi, this Jerry. And I think that what we'll do is we'll look through the email box. We'll look for the question and we will send it to our Center for Medicare & Medicaid Policy staff to take a look at it if they can respond to it for you.

Melanie Combs-Dyer: Melissa, I will tell you, you should expect an answer after October 31st though. I would imagine that you would not be receiving an answer from the SNF Policy people before October 31st, and you'll just have to factor that in as you try to decide whether you want to submit a settlement request or at least submit a request for a Potentials List.

Melissa Duhn: OK. And the last question I have on the Potentials List that we sent in, you said you'd have a 2-day turnaround time for the list. I received – I put mine in last week and I still have not received it. I got a confirmation that it was sent but …

Melanie Combs-Dyer: Thank you…

Melissa Duhn: … I've not received the list.

Melanie Combs-Dyer: … thank you, Melissa and it sounds like that is a flaw in our system. Let me ask that you send me specifically an email. My email address is melanie.combs-dyer, that's C-O-M-B-S hyphen D like dog Y-E-R @cms.hhs.gov. When I receive that email from you, we will start digging through the mailbox and see if we can't find it. It's possible that that came in on the day that the mailbox was down because we had gotten in so many requests that it got too full and so we will — we will search until we find it.

Melissa Duhn: OK, thank you very much.

Operator: The next question comes from the line of Kim Armahizer.

Kim Armahizer: Hi, my question is regards to the Potentials List and if we submit a request to receive our Potentials List, do we also need to submit the Administrative Contractor Agreement at the same time?

Melanie Combs-Dyer: That's a good question, and no you do not. To submit a Potentials List you just follow the instructions that are on the website or here in this slide deck and you submit your request, but you don't have to have any attachments. You don't have to have anything signed.

Kim Armahizer: OK, thank you. That's what it seemed like, we just wanted to verify.

Melanie Combs-Dyer: Yes, thank you for checking.

Kim Armahizer: Thank you.

Operator: The next question comes from Vicki Ament.

Melanie Combs-Dyer: Vicki?

Jamie: Hi, this is Jamie with ANTHC, and we just have some more questions on the Potentials List. If we submit the Potentials List, is that the same as a request to participate and does – if that's received by October 31st, do we also meet the deadline or does the settlement have to be turned in also?

Melanie Combs-Dyer: So it is – submitting a request for settlement is different than submitting a request for a Potentials List and if you – when you submit a – when you submit a – when you submit a settlement request, you are actually submitting a PDF document that has a signed legal document by an official at your hospital. You are also submitting a spreadsheet that lists out all the claims that you think meet the eligible claim criteria. That's what a settlement request is.

A request for a Potentials List is an email that does not have any attachments to it and it just says, "Hey, I'm having trouble getting started here. Can you send me a list of claims that are potentially eligible?" I recognize that there might be some that are not included because they're still with the MAC or there might be some that are included that shouldn't be because we received Part B payment, but at least it would be a start, a place for us to potentially begin our list.

And if you submit either of those before October 31st — on or before October 31st, you will be included in the settlement process. If you submit your request for a Potentials List by 10/31, it will be several more days after that before we respond and send you the Potentials List. Once you receive the Potentials List, you will then need to send back to us the signed Administrative Agreement and the full spreadsheet. Was that helpful, Jamie?

Jamie: It was, and from the time we receive the Potentials and get included, what is the timeframe to turn in the settlement request.

Melanie Combs-Dyer: We would ask that you try to hit a 14-day turnaround time, but I recognize that we will have, you know, lots of things going on at that time, but I would encourage hospitals to try to — when you receive the Potentials List to turn around your Administrative Agreement and submit it back to us within 14 days.

Jamie: Great, thank you.

Operator: The next question comes from the line of Lexie Emerson.

Lexie Emerson: Good afternoon. I'm from Mercy Health and we submitted at the end of September for several of our facilities and the sizes were very different. Some as small as about 25, others as large as close to 2,000, and we haven't received a response on any of those, but we've started to see on the Q to A website that those are no – those claims are no longer available on that site. So at what point should we call for a followup on that because it's a little concerning that they are showing that they're out of the appeals process yet we haven't heard anything back yet.

Melanie Combs-Dyer: Lexie, I'm going to ask that you send an email to the CMS email box asking that question and we will look into it.

Lexie Emerson: OK, great, thank you.

Operator: Your next question is from the line of Crystal Robinson.

Crystal Robinson: Hi, this is Crystal Robinson calling on behalf of Regions Hospital in St. Paul, Minnesota. My question is, we have a claim that we had appealed with the RAC and it was approved for payment, however, the RAC never submitted the information to CMS, I think, before the deadline of April 30th. And they approved our payment; however, we had not received payment and the RAC said they can't move forward at this time. Do we have to include that claim with the rest of the claims to receive the settlement or should we keep that one separate?

Melanie Combs-Dyer: Crystal, I'm going to ask that you send an email to our email box describing the situation that you just described here and I'll have someone give you a call. Make sure you include your phone number when you send us that email.

Crystal Robinson: Thank you.

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

Carl Barbie: My question has been answered. Thank you.

Operator: The next question comes from the line of Jeanne Winslow.

Jeanne Winslow: Hi, this is Jeanne Winslow from Brigham and Women's Faulkner Hospital. I did just have a question for clarification on the DCN that's to be used. I just wanted to make sure that it's the DCN that's listed on the adjustment for the RAC claim.

Melanie Combs-Dyer: Give us just 1 second.

Jeanne Winslow: All right.

Jerry Walters: Hi, this is Jerry. I just wanted to congratulate you on stumping the bureaucrats. But we are having a conversation here. We're trying to get the correct answer for you. Give us 1 more second.

Jeanne Winslow: Thank you.

Melanie Combs-Dyer: OK, it is on – the – we need the DCN of the remit following adjustment.

Jeanne Winslow: OK, thank you very much. So it will be on the 11H, just to clarify.

Melanie Combs-Dyer: Thank you, Jeanne.

Jeanne Winslow: Thank you.

Operator: The next question comes from the line of Judy Renschler.

Julie Renschler: This is Julie from Floyd Memorial Hospital and we were wondering if a new EOB is going to be generated for each of the accounts that are included in the CMS settlement?

Melanie Combs-Dyer: A new explanation of benefits?

Julie Renschler: Yes.

Melanie Combs-Dyer: It means that…

Julie Renschler: To be able to put – to be able to post the payment after the adjustment.

Melanie Combs-Dyer: Is that something that goes to a beneficiary?

Julie Renschler: Yes, but also the Electronic Remittance Advice would come to the hospital, which is just …

Melanie Combs-Dyer: I don't believe any notification is going to a beneficiary. So if an EOB goes to a beneficiary, then the answer would be no.

Julie Renschler: OK, so what about an Electronic Remittance Advice to the hospital that shows the denial but the adjustment on the payment?

Melanie Combs-Dyer: You will be receiving an email from the MAC telling you that the payment is on its way. Is that what you're asking about?

Julie Renschler: Well, we're asking about the amount for each individual account so that it will be able to be reflected in the system appropriately to post the payment.

Melanie Combs-Dyer: Well, remember, it's one single payment. It's a lump sum payment, or maybe two if you have a Round 1 and a Round 2.

Julie Renschler: Yes, I understand that part, but we just didn't know with each individual account if there would be something coming through on each individual account.

Melanie Combs-Dyer: Yes, here's what I can tell you. If you receive a prepayment claim denial – if you have a prepayment claim denial, then the settlement payment will be reported on the settlement payment line in the summary section of the remittance. If you have a postpayment claim denial settlement payment, that will be reported on the refunds line in the summary section of the remittance. Was that helpful?

Julie Renschler: OK, are you saying that it's in the – it's individual on each line, each account?

Jerry Walters: Here – I think, Melanie, if I could just chime in here. This is Jerry. I think the question really comes down to, you know, a question about what happens to the claim itself. Again, we are settling an amount, 68 percent of that net paid amount, for each individual claim that's considered, and then, obviously, we gross that, and there's a total value that gets paid. We are not – these claims remain denied in the Medicare systems, so there's not a reprocessing of the claim itself. This is a Settlement Agreement. Did that help?

Julie Renschler: Yes.

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

Mary Myslajek: Yes, this Mary Myslajek from Hennepin County Medical Center in Minneapolis, Minnesota, and I'm following up from listening to your last call, where there was quite a bit of discussion about how this might affect Medicaid payments that were made as a secondary payment for the deductible, and I think you've been clear in the earlier calls that you couldn't speak to other insurances. But you were asked, what was the CMS position on Medicaid secondary payments that had been received on these cases that would now be considered denials? Are there instructions from CMS to either the Medicaid programs or to providers? Thank you.

Melanie Combs-Dyer: Linda, is that one that you can answer?

Linda Uzzle: I think Jerry better answer that one.

Jerry Walters: Yes, hi, this is Jerry, and I think that perhaps — it's a very good question and it is one that we have not been particularly clear about. We continue to work with our Center for Medicare and State Operations to make sure that we get the right information. It's understandable, particularly when it comes to third-party liability and, you know, dually eligible Medicare beneficiaries and how that impact plays out.

So I think your question is, who remits to who or recovers from whom, and you would like instructions to that. Do I have that correct?

Mary Myslajek: Yes, that is correct, especially with regards to the Medicaid program. And a number of hospitals serve, you know, disproportionate share patients with, you know, we're providing services to many dual eligibles. So it is something that we would like to know what the CMS instructions are.

Jerry Walters: Yes, I thank you and…

Mary Myslajek: Thank you.

Jerry Walters: … I tell you, I will commit that we will put some information up onto the CMS website this week that explains the position and how that might be able to be handled.

Mary Myslajek: Great, thank you very much.

Jerry Walters: You're welcome.

Operator: Your next question comes from the line of Marcia Stein.

Marcia Stein: Hello?

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

Marcia Stein: This is Marcia Stein from Good Samaritan Hospital. My question is that we have several cases where we have written a letter for appeal to our MAC but they never responded. We have a certified receipt that they signed for it. So we sent the letter a second time and with certification that they signed for it and still no response. So we have appealed all of these cases, but no response from our MAC. Can we include those on our lists?

Maria Ramirez: Marcia, this is Maria Ramirez. Can you please send me an email with that information or send me —or actually I'll take your phone number and I'll call you and get the details and try to respond to your questions offline.

Marcia Stein: All right, Thank you. So, you're…

Maria Ramirez: Can you give me your telephone number?

Marcia Stein: Right now?

Maria Ramirez: Yes.

Marcia Stein: My phone number is area code XXX…

Maria Ramirez: Um-hum.

Marcia Stein: … XXX-XXX.

Maria Ramirez: All righty, I will call you.

Marcia Stein: Thank you.

Maria Ramirez: Sure.

Operator: The next question comes from the line of Brad Smyer.

Brad Smyer: Hi, this is Brad Smyer from DLA Piper. I have a question about whether a hospital may use the settlement to resolve an extrapolated overpayment? And if so, how the hospital would use the eligible claims spreadsheet to provide information about the extrapolated overpayment?

Just as a background, only a small sample of claims are typically denied as part of generating an extrapolated overpayment, and so if a hospital lists only the denied claims on the eligible claims spreadsheet, those claims only represent a small fraction of the total overpayment amount. So will CMS automatically tie those denied claims to the total extrapolated overpayment amount? And if not, how will a hospital account for that?

Melanie Combs-Dyer: So this is Melanie, and if you have an individual claim that was reviewed and denied that is part of the what you call the extrapolation sample, that certainly can be included in the settlement process. However, what impacts that would have on the universe of the fully extrapolated claims, you would have to talk to the review entity that performs that extrapolation to find out what the impact would be on the extrapolated amount. Was that helpful?

Brad Smyer: I guess it's as helpful as I'm going to get today.

Melanie Combs-Dyer: You can certainly look at the Q&A — the FAQs that we have posted to the website.

Brad Smyer: Um-hum.

Melanie Combs-Dyer: In Section A for general questions, question number 13 gives you that answer in writing.

Brad Smyer: So, just to make sure I understand then. If you were to list all the denied claims, essentially you would be looking for 68 percent on those specific claims that were reviewed and how you would get back all the rest of the money. You're saying, you have to go talk to whatever entity performed the audit.

Melanie Combs-Dyer: That is exactly correct.

Brad Smyer: OK.

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

Mary Harless: Hi, I just really have a followup to my earlier question. We — I have been following up on some of the claims that we had submitted for a Part A to Part B rebill and I logged into the FISS and saw that there is a – well it says, "FISS temporary hook for A/B rebilling claims."

So we've had this one in and, you know, these claims have to be – you'll get it at (inaudible), and so you have to rework them in the system. And so I'm just wondering, is this — are these being held? Are the A/B rebilled being held until after the Settlement Agreement? And if they are being held, how long can we expect these to be held?

Melanie Combs-Dyer: I — this is Melanie, and I don't know if they are being held in the system, but is this something that you it – is it a claim that otherwise meets all the criteria on the eligible claims list on slide 7, you're not just sure about criteria number 7, the hospital did not receive payment for the services of Part B claim, is that what you're asking about?

Mary Harless: Well, actually I don't believe that this one qualifies, but it's being held for this, you know, there's a code there that it's – some kind of temporary hook, but …

Maria Ramirez: I — can you clarify what you mean by held?

Mary Harless: Held, well it's in the FISS – I can see it in the FISS, and there is a 31796 issue code on the — on the line item with that particular claim. So in, you know, it's just – when I called — and our MAC is WPS. When I called them to see what the holdup was they said that this is temporary. They couldn't tell me any more other than that this claim is being held.

Maria Ramirez: All right. I think that we can follow up with WPS and find out exactly why this claim is being held in the system. If you like, I can give you a call back if you give a telephone number.

Mary Harless: OK, its area code XXX…

Maria Ramirez: Um-hum.

Mary Harless: XXX…

Maria Ramirez: Um-hum

Mary Harless: … XXXX.

Maria Ramirez: Thank you. Your name was Mary?

Diane Maupai: I think we're ready for our next question.

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

Frank Doll: Hello, my name is Frank Doll. I'm calling from Doylestown Hospital. I actually called the last — during the last conference call and asked a similar question. We sent our list and our Administrative Agreement in 09/19 of '14. I've not received any confirmation back of that, you know, that – that list came. I got an email saying that you got it but I sent my file encrypted and I guess I was concerned that you were not able to open that file.

Melanie Combs-Dyer: Frank, this is Melanie. Can you give me your phone number and I'll — we'll have somebody call you right after this conference call.

Frank Doll: OK, now I gave my phone number during the last conference call that was done and nobody ever called me back.

Melanie Combs-Dyer: Well, if you give it to me today, I will personally call you back sometime this afternoon.

Frank Doll: You're the best. I have a lot of confidence in you.

Melanie Combs-Dyer: Thank you.

Frank Doll: My number is XXX-XXX-XXXX.

Melanie Combs-Dyer: Give me the last four again.

Frank Doll: XXXX.

Melanie Combs-Dyer: I got XXX-XXX-XXXX, is that correct?

Frank Doll: Yes, that's correct.

Melanie Combs-Dyer: Frank and before …

Frank Doll: And also as a consequence I have — I have one question, but a two-parter. I have also identified after the last conference call that we had three claims that were both a DRG downgrade and a medical necessity denial, and as a consequences of the last call, it came to my attention that I could have put those on my list and I did not.

Melanie Combs-Dyer: When you say there were medical — they were DRG downgrade and a medical necessity denial, was it a medical necessity denial because the procedure was not necessary or a patient status medical necessity issue?

Frank Doll: It's a patient status medical necessity issue.

Melanie Combs-Dyer: Yes, those three can be included on your list.

Frank Doll: Yes, and so I, of course, I sent the list in 9/19 and I deselected those claims because I thought that DRG downgrades weren't to be included and I didn't realize that if it was both I could have put it on there. Can I – can I take care of that when I do my — when you guys send me back the response and I – can I add them on the second level of the …?

Melanie Combs-Dyer: We will add that to the agenda for our call with you this afternoon, Frank.

Frank Doll: OK, that would be great.

Melanie Combs-Dyer: And did you have another question?

Frank Doll: They were — they were my questions.

Melanie Combs-Dyer: OK, great. And just a reminder to everybody else on the line, if you have a claim that is denied for two reasons and one of those reasons is patient status denial, that is — that meets the criteria for number 1 being denied by – I'm sorry, number 3, being denied based on patient status. So if it's denied in, like in Frank's case because of DRG that was coded too high and medical necessity of the inpatient stay was not — didn't meet the criteria but outpatient did —that does meet criteria number 3, patient status criteria.

Frank Doll: Thank you.

Melanie Combs-Dyer: You're welcome, Frank.

Operator: Your next question comes from the line of Ernie de los Santos.

Melanie Combs-Dyer: Ernie?

Ernie de los Santos: Hi, I'm sorry. I had my line muted. My question comes from – My name is Ernie de los Santos, I'm from Appeal Academy. I talked to a lot of hospitals who are very concerned about the process that happens after Round 2, where the ALJ and the DAB have the opportunity to go back and look at every one of the items that was on the list in the Settlement Agreement. In order words, that's all been settled and everything, but the ALJ and DAB go back and look in.

There doesn't seem to be any time limit on how long the ALJ and the DAB can take to do that plus there's no mention of, well, what happens if the hospital disagrees with the decision made by the ALJ or the DAB to add or subtract something from the agreement. So I've just heard a lot of concern about that. There hasn't been anything written or said about that process.

Maria Ramirez: So this is Maria Ramirez. We don't have oversight over OMHA or the Departmental Appeals Council or Appeals Board, and so as you probably already know there is a backlog at those levels of appeal and, therefore, we need to be flexible. So the process that we have worked is that we will go ahead and issue the payment and once we receive confirmation or any errors — concerns from either OMHA or the DAB — we will then direct the MAC to take action to recover those payments that were issued that were ineligible for the settlement process.

Ernie de los Santos: They're already backlogged quite a bit now and it takes years to even get on there, you know, 'til you can get something scheduled now. So how are hospitals to judge whether or not, you know, is this going to take 5 years for them to actually come back and do this consideration?

I mean, do you see my — do you see my concern — do you see the concern of hospitals? They are just concerned that this is an ongoing process that doesn't seem to have any end date connected with it.

Jerry Walters: This is Jerry. Let me try to address that, and certainly I can understand the trepidations that a hospital or others may have. It is – it is our intent to resolve as many of these appeals as possible so that we can reduce the backlog and the timing it takes to get an appeal heard. So we — are expecting that there is a mutual benefit here between the hospital industry and the government in these instances to work collaboratively to get this done.

As part of our settlement or Administrative Agreement, we have included this, mentioned in paragraph seven, that we retain that right because we must if we have paid in error. We may not pay in error, and so I understand the concern. We are working with our colleagues throughout all the appeals tribunals to make this happen as efficiently as possible.

Ernie de los Santos: OK. I guess I'm just – I'm just saying that it seems to me because there are time limits on other things, even though sometimes those time limits may not be effective, but I think it would be — it would ease everybody's mind if there was some kind of written statement about, OK, this is how long the ALJ or the DAB has to do this. And this is a process that if the hospital then disagrees with the ALJ's assessment, there would be some way to appeal that, because right now there just doesn't seem to be anything about that.

Melanie Combs-Dyer: We will certainly pass your sentiments along to the Office of Medicare Hearings and Appeals and to the Departmental Appeals Board. Thank you, Ernie, for your question.

Operator: The next question comes from the line of Huntington Memorial Hospital.

Mechi Cabrera: Hello, this is Mechi Cabrera from Huntington Memorial Hospital. I just needed clarification. We had a couple of cases that were denied at the MAC level and we did rebill timely. However, for some reason, there was a systems glitch with Meridan and a year — a year and a half later, we have not received any payments. I'm assuming I can include that in the settlement.

Melanie Combs-Dyer: This is a case that you — it was denied. The initial claim was denied by the MAC. Did you appeal to the first level of appeal?

Mechi Cabrera: Correct.

Melanie Combs-Dyer: And do you — you filed that appeal timely, is that correct?

Mechi Cabrera: Correct.

Melanie Combs-Dyer: And criteria number 6, as of the date that you submitted your initial agreement to us, was the appeal still pending or you had not exhausted your appeal rights to the next level?

Mechi Cabrera: We had actually — we decided to rebill. We pulled — we got a dismissal and we rebilled the case.

Melanie Combs-Dyer: And what was the date of that dismissal?

Mechi Cabrera: You know, there are several dates because there are several cases.

Melanie Combs-Dyer: OK, if it …

Mechi Cabrera: I know ..

Melanie Combs-Dyer: … if it was a – if it was a long time ago and the ability to vacate or appeal to the next level has passed, then you would not meet criteria number 6 and so it would not be eligible. But just so to talk it through, perhaps you could give your phone number to Maria and she could call you after this conference call.

Mechi Cabrera: Sure. My number is XXX-XXXX-XXXX. My concern is we did follow the timelines and we rebilled on a timely basis but have not received payment.

Melanie Combs-Dyer: Yes, thank you for your – for your interest in the settlement process. We really appreciate it.

Operator: Your next question comes from the line of Victoria Holzman.

Victoria Holzman: Hi, I'm calling from HealthEast Care System. Do you want the Administrative Agreement printed on hospital letterhead or just plain paper?

Melanie Combs-Dyer: Just plain paper would be fine.

Victoria Holzman: Thank you.

Melanie Combs-Dyer: It's coming in as a PDF and so however it is that you can get that back to us, it's fine. It does not need to be on hospital letterhead. It is important, I will note, that you make sure that the name of the hospital in full appears on the various lines. I think it's written in a way that if you type it in the first place it autofills in the other places. If you find out the name of your hospital is too long to fit, please let us know. But if you can type it in and your name – your – the name of your hospital shows up, then you're good to go with just plain old paper.

Victoria Holzman: Thank you very much.

Operator: Your next question comes from Juli Zopf.

Juli Zopf: Hi, Juli Zopf, Saint Joseph/Candler Hospital. We would like to add a column that gives an account number so we can locate the account. Will that be a problem?

Melanie Combs-Dyer: This is Melanie, and we encourage people not to make any adjustments to the spreadsheet. However, if you think it is really critical that you add that new column with the account number, you may. I will tell you; however, your

spreadsheet will go the end of the list. We are processing first those who are able to send us a spreadsheet that is in the CMS format. And so as long as you don't mind waiting the extra time, you can certainly make that modification.

Juli Zopf: Thank you.

Operator: Your next question comes from the line of Cindy Scofield.

Jo Dilbeck: Hi, this is Jo Dilbeck from Oroville Hospital. We have a question. We have already submitted our agreements for — in the initial Round 1 and agreed to those. On that list there were a substantial number of claims where we had not had a recoupment of the original payment. My question is, how is the recoupment/repayment going to be handled on those claims since we will – we currently have the use of 100 percent of the net payment and we should only get 68 percent through this Settlement Agreement? How is that remaining 32 percent going to be either recouped, repaid — see where I'm going with this?

Melanie Combs-Dyer: It's one lump sum payment, and so whatever it is that you owe back on that line would be netted out in the settlement payment that comes to you at the end. Did that make sense?

Jo Dilbeck: Well, we've already received 100 percent. So technically there would be nothing left due to us. We owe money to you for all intents and purposes.

Melanie Combs-Dyer: So Jo, how about if we give you a call after this — I'm sorry.

Donna Sanders: Yes.

Melanie Combs-Dyer: Go ahead.

Donna Sanders: So the 32 percent that is due to CMS, a new receivable or overpayment will be established for that 32 percent and it will follow the normal process.

Jo Dilbeck: OK.

Donna Sanders: Hi, this is Donna Sanders from OFM.

Melanie Combs-Dyer: Thank you, Donna. Jo, was that helpful?

Jo Dilbeck: Yes, thank you.

Operator: Your next question comes from the line of Kristen Weetenkamp.

Kristen Weetenkamp: Hi, yes. I have a question regarding the completion of the spreadsheet. There are some claims that we can't seem to find the appeal number. Is it possible that we can leave any fields blank when we submit the spreadsheet? Or what are your recommendations if we cannot find the appeal number?

Maria Ramirez: Did you mean the appeal number for the level 1 or level 2?

Kristen Weetenkamp: Yes.

Maria Ramirez: If you have the appeal number for the level 1, we encourage you to please include that. We will be able to identify your claims a lot faster if you have at least the QIC appeal number. If you have none of the appeal numbers, at a minimum, you need to provide the claim number.

Kristen Weetenkamp: OK, OK. Thank you and then also just as followup to the — someone else's question. If we excluded a claim that we weren't sure would be eligible or not, would you come back in the reconciliation period and say that was — that we missed some?

Melanie Combs-Dyer: Wait, can you repeat the question?

Kristen Weetenkamp: So there — one gentleman asked about the — like the dual denials. If he had excluded them from his settlement spreadsheet, would that – would you have come back to him and said, "Oops, you forgot one" and this is included as well.

Melanie Combs-Dyer: Hang on 1 second. We're – let's see if we can find the answer to that.

Kristen Weetenkamp: OK.

Melanie Combs-Dyer: I'm sorry for the delay Kristen. I'm going to direct you to question C19 on our FAQ. I think that's probably the best way to get your information. It says that the question is, "will CMS and its contractors validate all claims on a hospital's eligible claims list or only a sample?"

And the answer is, "CMS and its contractors will validate all information about the QIC level and below. CMS and its contractors will validate a sample of information about the ALJ- and DAB- level cases. After the settlement payments are issued, OMHA and the DAB will conduct a full review on all cases at their level. If the ALJ or DAB identify errors in the settled claims, CMS will direct the MAC to take recovery action for claims that were ineligible for settlement that were inadvertently included in the agreement or pay providers the settlement amount for claims pending appeals that were inadvertently omitted from an agreement."

Kristen Weetenkamp: OK, yes, that's helpful. Thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next question comes from the line of Colette Boudreau.

Colette Boudreau: Hi, my question has been answered.

Operator: Your next question comes from the line of Ike Verano.

Ike Verano: Hi, this is Ike from Torrance Memorial. My question would be, if we submit the settlement today and we have scheduled ALJ hearings, let's say, Thursday - Friday and some claims that are due for a DAB or an ALJ this coming Thursday or Friday, what will happen to those or do we still initiate that level of appeal?

Maria Ramirez: Can you tell me again, or could you clarify — did you say that you are going to submit your settlements today?

Ike Verano: Yes, just in case, yes.

Maria Ramirez: So, essentially the way that we've laid out the process is that as soon as you submit your request, within a business day or two we will send some communication to all the appeal tribunals so that they can pend the appeals and essentially not work them while we're going through the negotiation process and, of course, the settlement. And so, I guess, it would be up to you if you decide to move forward with the settlement and whether or not you want to pursue the appeal, but at the ALJ level or the hearing I should say — or if you want to just go ahead and send us your request and we will make sure that it is — we notify the Office of Medicare Hearings and Appeals as soon as possible so that they can set that claim aside for hearing.

Ike Verano: So what you're saying is when I — if definitely I will be sending the agreement today, not to worry about those scheduled hearings or not to worry about those timeliness on initiating the next level for Thursday or Friday?

Maria Ramirez: Correct.

Ike Verano: OK, all right. Thank you.

Operator: Your next question comes from the line of Kelley Steincamp.

Kelley Steincamp: Hi, this is Kelley Steincamp from LSU Health Sciences Center. I wanted to see if Maria could call us back, too, regarding claims that we submitted to — for first

level appeals — timely, and we have certified receipt proving that — that they do not show received and we had to resend the information.

Maria Ramirez: Can you confirm that you mean claims for processing or do you mean appeals?

Kelley Steincamp: I mean appeals. I'm sorry, thank you.

Maria Ramirez: Sure, what is your telephone number?

Kelley Steincamp: XXX-XXX-XXXX.

Maria Ramirez: And what was your name again, I'm sorry?

Kelley Steincamp: Kelley Steincamp.

Maria Ramirez: Thank you.

Kelley Steincamp: Thanks.

Operator: Your next question comes from the line of Bill Napier.

Bill Napier: Yes, Bill Napier, St. Mary's Medical Center. A question regarding the Potentials List. If we get that list and you say we have 14 days after to send in the agreements and that falls past the 31st, do we still have to have the agreement in before the 31st?

Melanie Combs-Dyer: Nope, if you have your Potentials List in by the 31st, you're good.

Bill Napier: OK, so if we go to like the – I don't know, say for example, the 27th, then we have 14 days after that.

Melanie Combs-Dyer: That's right.

Bill Napier: OK. And when do you think I would get the Potentials List if I email you today?

Melanie Combs-Dyer: Well, we've been keeping up about a 2-day turnaround or 3-day turnaround. We did have a situation last week where the mailbox got full. We think that we have put in place the technology to avoid that from happening again in the future, but as we get a little closer to the due date, I am worried that we're going to get a lot of requests for Potentials Lists and so it might be closer to 4 or 5 days. But if you can get your request in before the 31st, you'll be good to go.

Bill Napier: Because of — yes, I'm one of the ones that got my request in last week and I still have not heard anything.

Melanie Combs-Dyer: I apologize. If you could just resubmit it, that would be very helpful.

Bill Napier: I'll email you today.

Melanie Combs-Dyer: Thank you.

Operator: Your next question comes from Nicky Jamison.

Nicky Jamison: Yes, hello. I think the question was already asked, but I did want to clarify. On the settlement spreadsheet, in the column F for the appeal number, I guess those appeals would vary if it's the ALJ or QIC or depending on what level. Does that – is that necessary to be filled in?

Maria Ramirez: It needs to be – I'm sorry. If you have that information, we encourage you to include as much information as possible because that really expedites our ability to search the claims. And you have to remember we are going through thousands of claims through the system. So the faster we can identify the claims, the faster we will get our response back.

Melanie Combs-Dyer: But Nicky, this is Melanie. If you do not have an appeal number, let's just say you're at the ALJ level and you don't have the appeal number at the ALJ level but you do have the appeal number at the QIC level, ...

Nicky Jamison: Um-hum.

Melanie Combs-Dyer: … you should tell — you should list on the spreadsheet the QIC appeal number, that will help us find it.

Nicky Jamison: I know a lot of them, we definitely have the initial letter. So I can easily identify those. It's just, you know, the higher levels I don't have.

Melanie Combs-Dyer: Well, if you can find it, then please include it, and if you can't, then tell us the best you know.

Nicky Jamison: OK, thank you.

Melanie Combs-Dyer: Um-hum.

Operator: Your next question comes from the Jozette White.

Jozette Cook-White: I am — I am in need of some clarification regarding the Potentials List. When we send that email to request the list and we receive a response, does the provider have an opportunity to add additional claims that they have identified are eligible to that list or must – must we stick to the list that we receive?

Melanie Combs-Dyer: No, it is the former. It is really just a starter list. It is an idea of claims that may potentially be eligible for settlement. It will include some things that you need to take off the list, like things that — appeals that are still in process at the MAC first-level appeal and it may include some claims that are no longer eligible, that don't meet one of the — one or more of the criteria.

So it will not be a perfect list. It is just a Potentials List, and you should make whatever modifications you need to turn it into the eligible claims spreadsheet and you should add your Administrative Agreement, and within 14 days, get that back to us and you should be good to go.

Jozette Cook-White: Thank you.

Operator: Your next question comes from Joy Cagle.

Joy Cagle: Hello, this is Joy Cagle calling from Hugh Chatham Hospital in Elkin, North Carolina. First, I just want to thank Ms. Ramirez for the followup from the October 9th call, but the — there were a couple of questions about Level 1 appeals that had languished as well that had not been answered by the MAC and so that call was taken offline as well and I'm – I know of at least five other providers in our jurisdiction that are having problems with rebills that have not been paid that are beyond — well beyond the appeal deadline but were filed in a timely fashion.

So just — those are just two examples of some issues that more than one provider is having and just would like to request that that be addressed in detail or that those can be included in the settlement. I know that you all are, you know, you all are looking at, you know, pretty tight parameters on what you can put on the settlement, but we've met the obligation in both of those examples and to have a — one provider — get special attention is really not fair to the providers who really aren't in the call queue. So that's just a comment said respectfully and with much appreciation for the special attention we got on the 9th.

Melanie Combs-Dyer: Thank you Joy. I'm afraid at this time, if you don't meet all of the criteria on the eligible claims spreadsheet — on the eligible claims criteria list, that claim would not be considered eligible for settlement and cannot be included on the spreadsheet. And if you do include it, we will mark it down as a disagree one that needs to come off of the list, but thank you anyway.

Joy Cagle: OK, so, it would just be kind of – you're third rock from the sun, that's just the way the ball bounces situation.

Melanie Combs-Dyer: I'm so sorry — so sorry Joy.

Joy Cagle: OK, all right. Well, and then the – OK. Well, thank you for taking my call. Ms. Ramirez, I did get followup from our MAC. So thank you so much.

Maria Ramirez: I'm glad to hear that. Thank you.

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

Andrea Dawes: Hi, this is Andrea with Salinas Valley Memorial Hospital and to follow up on what the last participant was just saying. We have a lot of problems with the A/B rebills falling to 39015 or 31796, and I was told the other day by a supervisor at Nordian that it's a FISS problem and they have no idea for resolution, and some of these I've been trying to get resolved for well over a year. And I think that's what a lot of the providers are talking about. And I know that's not necessarily what this call is about, but is there any way CMS can help with this because I have, I want to say, at least 25 claims sitting there, and they're saying it's a FISS issue and it's been going — and these A/B rebills were submitted timely, but they're not processing.

Maria Ramirez: All right. Can you give me your telephone number and I will make sure to have the contractor follow up with you?

Andrea Dawes: Yes, it's XXX-XXX-XXXX.

Maria Ramirez: Um-hum, XXX?

Andrea Dawes: Yes, and my extension is XXXX.

Maria Ramirez: All right. And what was your name again, please?

Andrea Dawes: Andrea Dawes, D-A-W-E-S, with Salina Valley Memorial Healthcare System.

Maria Ramirez: Thank you.

Andrea Dawes: Thank you.

Operator: Your next question comes from the line of Rebecca Scott.

Rebecca Scott: My question has been asked. Thank you.

Operator: The next question comes from Sandie Carroll.

Sandie Carroll: Yes, we would like to know if — what defines a denied claim? Do you actually have to get a demand letter or is it enough to get a remittance advice on your remit?

Melanie Combs-Dyer: Was it something that was denied following prepayment review or postpayment review?

Sandie Carroll: Postpayment.

Melanie Combs-Dyer: I believe on postpayment review it is not considered a denied claim until there is a demand letter. So if you, for example, have received a notification from the recovery audit contractor, they're sending you a review results letter and they say, "Thank you for sending in your medical records. We reviewed them and you didn't meet the criteria and so we're denying." It's a patient status denial. But you have not received a demand letter, that one cannot be included. That does not meet the eligible — the definition of an eligible claim — a denied claim.

Same thing with the QIO. If the QIO sent you a letter and says, "We've done a review and this admission was not appropriate. It could have been done as an outpatient. It didn't need to be done as an inpatient." But you have not received a demand letter yet, that is not a denied claim and so that is not eligible for settlement.

Sandie Carroll: OK. On some of these we have received what our RAC consider an SB, the intent to take back with the denial remark on our remittance advice, but we haven't received the demand letter, but it has hit our remittance advice. So in those cases, can those be included, or no?

Melanie Combs-Dyer: They cannot be included and, hopefully, there's a short time period between when it shows up on your remit and when the actual money gets taken — when the demand letter goes out.

Sandie Carroll: These have been quite a while.

Melanie Combs-Dyer: You may want to follow up with us offline. Do you have a phone number of someone at CMS that you can call?

Sandie Carroll: No, can I get your number and I can call you?

Melanie Combs-Dyer: Tell you what, you give us your number Rebecca – this is Rebecca, right?

Sandie Carroll: It's Sandie Carroll.

Melanie Combs-Dyer: Oh, Sandie, I'm sorry.

Sandie Carroll: Yes.

Melanie Combs-Dyer: I'm sorry, Sandie. Sandie, can you give us your number?

Sandie Carroll: Um-hum, it is XXX-XXX-XXX, extension XXXX.

Melanie Combs-Dyer: Great, Sandie. I will have someone give you a call back after this call.

Sandie Carroll: All right, thank you.

Operator: Your next question comes from Sandy Daemen.

Sandy Daemen: Yes, hi, good afternoon. I originally emailed my proposal settlement spreadsheet on 9/22 and I have not received any response back.

Melanie Combs-Dyer: Can you give me your name, again?

Sandy Daemen: Sandy.

Melanie Combs-Dyer: So, it's another Sandy. Sandy, can you give me your phone number?

Sandy Daemen: Yes, it's area code XXX-XXX-XXXX.

Melanie Combs-Dyer: Great, Sandy number 2, we will call you as well and we will try to find that missing spreadsheet.

Sandy Daemen: Thank you.

Melanie Combs-Dyer: Um-hum.

Operator: Your next question is from Gina Bowman.

Gina Bowman: Hi, this is Gina Bowman from Labette Health in Parsons, Kansas. You stated that the payment will come in a lump sum. I just wanted to have some clarification. I know historically any payments we receive on RAC cases, whether it be an overturn or a reversal — its comes to us, but there's no identification as to the patient it applies to. How will we identify which cases are included in this lump sum payment?

Melanie Combs-Dyer: You will have — you have submitted to us an eligible claims spreadsheet, the MAC will send back to you an agree list and a disagree list. If you send

— if you hit Reply All to that email and you tell the MAC and CMS that you want to proceed with payment on that agree list, the next thing you will see is an email from the MAC saying I've issued payment on that agree list and that email will then let you know that you should pull up that agree list spreadsheet and that will be your list of claims.

Gina Bowman: So the total dollars on the agree list should match the lump sum payment.

Melanie Combs-Dyer: Exactly. So you will know right from that agree list what to expect in terms of a lump sum payment. And if you had a disagree list and you elect to proceed, then you will in a separate email submit a second spreadsheet and a second Administrative Agreement. You'll go all the way through that process, and at the end of that process, you will receive a spreadsheet that will tell you again a new lump sum payment amount. And you will then get a second lump sum payment amount for whatever is on that spreadsheet.

Gina Bowman: OK, thank you.

Operator: And the next question comes from Cindy Scofield.

Jo Dilbeck: This is Jo Dilbeck again from Oraville Hospital. The question arises on – from the previous speaker, where you say that the lump sum that we're going to receive equals the amount of the net settlement on the agreements list, and this goes back to my original question about — on that list there are claims which we have not received a recoupment on. So we have already been paid 100 percent of the claim and what I'm hearing is you're going to pay us that 68 percent then again. So are you going to recoup that 68 percent again?

Melanie Combs-Dyer: I believe our spreadsheet has the correct formula in it. So it will know whether it's a take back or it's a pay.

Jo Dilbeck: No.

Melanie Combs-Dyer: Donna, am I saying that correct?

Jo Dilbeck: No. If the – we have the column that shows the net payable. You have the collection column, which is zero, and then you're showing 68 percent in the net payable, the settlement column, 68 percent of that full DRG, when we've already received 100 percent, and there's been no recoupment on this.

Donna Sanders: Hi, this is Donna Sanders from CMS. If there is a payment that's due and if there is an amount due from the provider, so the 32 percent — that information, that data, will be netted together, and then if there's a balance left that's due, that balance left will be refunded back to the provider. If there's no balance due and the provider

owes Medicare, a new receivable will be established and that new receivable will have a new demand date and it will follow our normal processes. Does that answer your question?

Jo Dilbeck: Not really, but I guess we just have to wait and see what happens.

Melanie Combs-Dyer: Jo, try it again, ask your question one more time.

Jo Dilbeck: OK. On the original – on the agreements list …

Melanie Combs-Dyer: Um-hum.

Jo Dilbeck: … column L says original inpatient claim amount posted…

Melanie Combs-Dyer: Um-hum.

Jo Dilbeck: … payable amount prepay.

Melanie Combs-Dyer: Yes.

Jo Dilbeck: Collected amount is zero.

Melanie Combs-Dyer: Um-hum.

Jo Dilbeck: These were prepays. We have already – no, not prepay …

Melanie Combs-Dyer: They're postpays, right?

Jo Dilbeck: Postpay, sorry.

Melanie Combs-Dyer: Um-hum.

Jo Dilbeck: They're postpays, collected amount is zero.

Melanie Combs-Dyer: Um-hum.

Jo Dilbeck: CMS net settlement amount in column N is 68 percent of column L, but we've already received 100 percent of column L.

Melanie Combs-Dyer: So I think what you will see then is a negative number saying you owe us money on that one.

Jo Dilbeck: The question is, where are we going to see that because the previous person — the question from the previous person was that the number we see on this net settlement, this agreement list —is what we will see is a lump sum.

Melanie Combs-Dyer: I'm sorry, I will clarify. For the majority of you who are going to be receiving a payment through this process, when you add up all the pluses and you add up all the minuses on the spreadsheet, your sum total will be plus and you will be getting a check. For those of you who have more minuses than pluses on the spreadsheet, we will be sending you a revised demand letter and you will be then paying us back.

Jo Dilbeck: There are no — just — I hate to belabor this, but there are no minuses on our spreadsheet.

Melanie Combs-Dyer: Have you received your — a validated spreadsheet yet?

Jo Dilbeck: Yes …

Melanie Combs-Dyer: OK, Jo …

Jo Dilbeck: … and we have submitted our agreement to it.

Melanie Combs-Dyer: Jo, can we have your telephone number and we will call you after this call?

Jo Dilbeck: Yes, you can. It's XXX-XXX-XXXX.

Melanie Combs-Dyer: Great, thank you so much, Jo.

Jo Dilbeck: You're welcome.

Female: Part B.

Diane Maupai: OK, thank you very much. I'm going to interrupt the questions right now and let Maria come back on to clarify a previous answer.

Maria Ramirez: Hi, this is Maria Ramirez again, and just to clarify to the gentleman who was asking about the upcoming hearings at the ALJ level. We would like to actually encourage you to get in touch directly with the ALJ team that will be hearing your cases — I think you mentioned Thursday, Friday this week. You may just want to let them know that you have submitted a request — or a settlement request to CMS and that way it will not look like you just didn't show up to the hearing.

Just to make sure, we will do our part and communicate internally to the Office of Medicare Hearings and Appeals, but I think that it would probably be very helpful if you reach out to the ALJ team and let them know as well that you have submitted a settlement request. Thank you Diane.

Diane Maupai: Thank you. We're ready for our next question Salema.

Operator: Your next question comes from Melissa Duhn.

Melissa Duhn: I believe my answer was already taken care of, or my question rather than that. Thank you.

Operator: Your next question is from Crystal Robinson.

Crystal Robinson: Hi, this is Crystal Robinson for Regions Hospital again. Let's say if we have a hospital that has multiple NPI numbers and we need to request for the Potentials List, can we include the multiple NPI numbers on that request or do I have to send an email for each NPI number?

Melanie Combs-Dyer: So, I'm going to ask you to look at the slide deck and look at slide 9, and you can see that to request a Potential's List, you send one email to MedicareAppealsSettlement@cms.hhs.gov and in the subject line you say "Request for Potentials List" from — insert the provider name and then insert the six-digit provider number. Then in the body of the email, you should list each NPI number associated with that provider number. Does that answer your question?

Crystal Robinson: Yes, thank you.

Operator: Your next question comes from David Teichman.

David Teichman: Hi, this is David Teichman from Englewood Hospital. Just a quick question. We submitted our spreadsheet towards the end of September, and I received the automated confirmation. We haven't gotten anything since then and I'm not sure if it's been too long.

Melanie Combs-Dyer: David, give us your phone number and we will call you to confirm.

David Teichman: OK. My number is XXX-XXX-XXXX.

Melanie Combs-Dyer: Thank you David.

David Teichman: Thank you.

Operator: Your next question comes from Mary Harless.

Mary Harless: My question has been answered. Thank you.

Operator: Your next question comes from Mary Myslajek.

Mary Myslajek: Yes, thanks. This is from Mary Myslajek from Hennepin County Medical Center in Minneapolis. And I just want to refer back to something I think was spoken about at the beginning of the call. I think it was mentioned you had receive 88,000 requests already or …

Melanie Combs-Dyer: 88,000 claims.

Mary Myslajek: Claims.

Melanie Combs-Dyer: 88,000 appeals, requests for 88,000 appeals.

Mary Myslajek: OK. Do you have any way of telling us maybe how many hospitals have already requested from you?

Melanie Combs-Dyer: Not at the time.

Mary Myslajek: OK, thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next question comes from Vicki Ament.

Jamie: Hi, this is Jamie with Alaska Native Medical Center. After we submit the initial settlement request, one of the earlier questions was they were finding other claims that weren't initially included. Is there any opportunity to add claims later, maybe at the — on the disagreement list? Or is the first settlement pretty much all we can add?

Melanie Combs-Dyer: You would have an opportunity when the disagreement — when the disagreement, no …. Hang on 1 second, we're going to have an internal conversation.

So if you choose to — if you get your validated list, say it's an agree list and a disagree list back from CMS, and you choose to proceed, at that point you could take your disagree list and you could add whatever you think may have been missing to that disagree list and you can submit that into round 2.

Jamie: OK and is round 2 the final review?

Melanie Combs-Dyer: Yes, although sometimes there could be a discussion period that is involved towards the tail end of round 2. If you and the MAC are going back and forth

on trying to resolve those last few claims. So — but I would – I would definitely encourage you to try not — to not wait until the end, try to include it on your round 2 submission.

Jamie: Great, thank you.

Operator: Your next question comes from the line of Tish Hollingsworth.

Tish Hollingsworth: Good afternoon. My question, and maybe not even a question but a followup to the question that was asked earlier about the impact on subsequent skilled stays, if that claim that is part of the appeal settlement is the 3-day qualifying stay. I know your response was that you felt like probably you couldn't answer it and that we should not expect an answer before October 31st, but it's just something I think is very critical in some of the hospitals' determinations on whether they move forward, not only because it may impact skilled units in their own facility or swing bed stays, but also the impact — especially in smaller communities when it's the nursing home down the street that has those skilled stays, and the impact on the patient that then those claims are subsequently denied. So I'm just asking if you could please clarify that for us or tell us who can clarify it so that we can move forward with appropriate decisions?

Melanie Combs-Dyer: I believe that those are denied claims. The inpatient claims are denied claims. They will remain denied claims in the system and whatever impact that might have on the skilled nursing facility claim, I think you just have to assume that it's whatever normally happens when you have a denied inpatient claim.

Tish Hollingsworth: OK, thank you.

Melanie Combs-Dyer: Um-hum.

Operator: Your next question comes from Susan Kehoe.

Susan Kehoe: Hi, this is Susan Kehoe from Mather Hospital. My question is, I think it's similar to one that was asked before. I have two claims where we submitted the first level of appeal and I was told last week that they were still in process, that a decision hasn't been made. How do I handle those two cases?

Melanie Combs-Dyer: Are those ones that you want to include in your settlement list?

Susan Kehoe: Yes.

Melanie Combs-Dyer: So because they are still pending in the appeal process, you meet criteria number 6, I think it is, and so you would include it on the list.

Susan Kehoe: OK, very good. Thank you.

Melanie Combs-Dyer: Um-hum.

Diane Maupai: OK, this is Diane Maupai. We have time for one more question.

Operator: Your final question comes from Ike Verano.

Ike Verano: My question, no, Maria, thank you very much for the followup on that. I was the one who asked about the ALJ schedule. But my question with the — circling back to the eligible list and the agree list or disagree list. So when we get the agree list back with the disagree ones, we will remove the disagree from that list and Reply All to the — to Medicare and to the MAC. Then with the disagree list, we move forward to round 2, would that be correct?

Melanie Combs-Dyer: Pretty close. You get an email from the MAC that contains two attachments — an agree list and a disagree list, or it might actually be one spreadsheet with two tabs, I'm not exactly sure, but they say it's pretty easy to tell the agrees from the disagrees.

Ike Verano: Um-hum.

Melanie Combs-Dyer: You will reply to that email and you will say "I want to proceed" or "I want to abandon."

Ike Verano: OK.

Melanie Combs-Dyer: And if you choose to proceed, then you know from your agree list what your payment amount or your take back amount will be.

Ike Verano: Correct.

Melanie Combs-Dyer: And you will take the disagree list and you will sign a new Administrative Agreement and you will send a separate email to CMS — CMS mailbox, thus beginning round 2.

Ike Verano: So the disagree list will remove it from the agree list that we would be acknowledging or accepting the settlement with, right?

Melanie Combs-Dyer: Can you repeat that?

Ike Verano: On round 1, once we get that agree list back we are going to remove the disagree list from there and Reply All, saying that we are going for the settlement.
Melanie Combs-Dyer: When you send us the proceed decision, you don't need to attach anything to the email. You just say …

Ike Verano: Oh, OK.

Melanie Combs-Dyer: … wait, I'm sorry, Terry.

Terry White: Hi, this is Terry White. You can just leave the email as is, leave all attachments there because it will be helpful for us to know and just hit Reply All.

Ike Verano: OK.

Terry White: You don't have to take the disagreement. And then start round 2, you'll then take that disagreement spreadsheet, review it, and make sure that you don't have anything else that you don't agree is eligible, and then that disagree spreadsheet is then submitted with your new agreement after you've reviewed it.

Ike Verano: Got it, thank you very much.

Melanie Combs-Dyer: Thank you Ike.

Ike Verano: All right.

Additional Information

Diane Maupai: Thank you very much. This is Diane and unfortunately that's all the time we have for questions today. And I want to remind you that on slide 14, the first bullet is a link for more resources. So you want to bookmark and check that often for FAQ updates. And the third bullet on slide 14 is the email address for submitting any further questions.

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

On slide 16 of the presentation you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary and we hope you'll take a few moments to evaluate your MLN Connects Call experience.

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

Operator: This concludes today's call.

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