MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
2016 Hospital Appeals Settlement Update Call
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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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 the call over to Hazeline Roulac. Thank you. You may begin.

Announcements and Introduction

Hazeline Roulac: Thank you, Holley.

Hello, everyone. Thank you for joining us today. I am Hazeline Roulac from the Provider Communications Group here at CMS. Welcome to this MLN Connects National Provider Call on the 2016 Hospital Appeals Settlement Update. MLN Connects Calls are part of the Medicare Learning Network®.

On November 3, 2016, CMS provided details on the process to allow eligible providers to settle their inpatient status claims currently under appeal using the Hospital Appeals Settlement process. This National Provider Call is a follow up to the November 16 call. During today's call, CMS subject matter experts will give an update on the settlement and the settlement process that started on December the 1st.

Before we begin, I have a few announcements.

There is a slide presentation for this call. You should have received a link to the presentation in your registration email. If you have not already done so, please view or download the presentation from the CMS website at go.cms.gov/npc. That's go.cms.gov/npc. Select today's date from the list and click on Slide Presentation under Call Materials.

Second, this call is being recorded and transcribed. An audio recording and a written transcript will be posted to the MLN Connects Call website under Call Materials. We will put an announcement in the MLN Connects Provider eNews when these are available.

At this time, it is my pleasure to turn the call over to Ronke Fabayo. Ronke?

Presentation

Ronke Fabayo: Thank you.

Good afternoon, everyone. Thank you for participating in the second Medicare Learning Network National Provider Call on the 2016 Hospital Appeals Settlement process. My name is Ronke Fabayo, and I am the Deputy Director of the Division of Medicare Debt

Resolution in the Financial Services Group here in OFM in CMS. Today, presenting with me will be Amanda Burd, Casey Welzant, and Morris Platter.

Moving on to slide 4 to cover our agenda. Today, we're going to discuss the overview of the Hospital Appeals Settlement Process. We're going to go over the eligibility criteria. We're going to go over the process. And then we're going to take questions and answers.

Overview of Hospital Appeals Settlement

Moving on to slide 5, overview. On December 1, 2016, CMS opened the 2016 Hospital Appeals Settlement process. Specifically, CMS began accepting requests from eligible providers who wish to settle their inpatient status claims under this administrative settlement process. The 2016 process is similar to the process used to resolve inpatient status claims in 2014.

Eligible hospitals who wish to enter into the process may be willing to withdraw – must be willing to withdraw their pending appeals in exchange for timely partial payment. We have received a lot of Expressions of Interest to date. We've – the process has been going a lot smoothly and really smoothly and really well. We believe that the changes we instituted from the 2014 process have helped make things smoother this time around. Casey will highlight for you some of the problems that we – that we're experiencing in the process thus far during her presentation, as well as the mitigation procedures we have put in place to address those problems.

Moving on to slide 6, settlement details. As part of this administrative process, CMS is proposing to make a partial payment at 66 percent of the net payable amount of the denied inpatient claims. As a condition of settlement, hospitals must agree to the dismissal of all their appeals associated with the settlement. This settlement would serve as the final and legal resolution of the eligible claims settled.

Now, I'll turn it over to Amanda to go over the eligibility criteria.

Eligibility Review

Amanda Burd: Thanks, Ronke.

On slide 7, it's a review of the eligible providers. The facility types eligible for this settlement remain the same as the 2014 Hospital Appeals Settlement. The following facility types are generally eligible to submit an Expression of Interest. These are acute care hospitals—including those paid under the Prospective Payment System, PPS, or the Periodic Interim Payment, PIP, and the Maryland waiver hospitals—as well as critical access hospitals. Please note that otherwise eligible providers may be excluded from this settlement process based on pending False Claims Act cases or other investigations.

The following types of facilities are not eligible to submit an Expression of Interest for this process. And those include psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment Systems, inpatient rehab facilities, and long-term care hospitals as well as cancer and children's hospitals. Note that providers with claim appeals that do not meet the eligibility criteria for this settlement can check the OMHA website for information on the settlement conference facilitation pilot.

Moving on to slide 8. It's a review of the eligible claim types. To be eligible for this settlement, a claim must – for it to be eligible for this settlement; a claim must meet the following criteria. The claim was not for an item or service provided to a Medicare Part C enrollee, meaning that it was a fee-for-service claim; the claim was denied due to a patient status audit conducted by a Medicare contractor, including the MACs, the RAC, the CERT contractor, the OIG, or the ZPIC.

These reviews were performed on the basis that the service may have been reasonable and necessary but treatment on an inpatient basis was not. And that the claim has a date of admission prior to October 1, 2013. Further, as of the date that the provider signs and submits their Administrative Agreement, the appeal decision was still pending at the ALJ or the DAB or that the provider had not yet exhausted their appeal rights at the ALJ or the DAB. Further, the provider cannot have received payment under Part B for these services. CMS notes that we believe that there are no patient status claim denials at Level 1 and Level 2 with dates of admission prior to October 1, 2013, eligible for this settlement and, therefore, that is not an eligibility criteria in the 2016 process.

At this time, I will turn it over to Casey to walk us through the process.

Process Review

Casey Welzant: Thank you, Amanda.

Hello, everyone. As Amanda stated, my name is Casey Welzant, and I will be doing a review of the process for hospital appeals. I'm going to try not to make this too repetitive of everything that we said on our November 16th call. But I want to make sure we touch on the main process points in case we have any people with us today that were not on our previous call.

If you are a facility that met the eligibility criteria that Amanda just went over, you're welcome to initiate the settlement process. In order to initiative the settlement process, hospitals should complete an Expression of Interest. This document can be found on our website, which is go.cms.gov/HASP2016. This link is case-sensitive. So, please be sure that you capitalize the H-A-S-P.

Once the Expression of Interest is completed and signed, it should be submitted to CMS at medicareappeals – and that's plural – settlement@cms.hhs.gov. We ask that in the subject line of your email to CMS you include the provider name, the six-digit provider

number or PTAN, and the words "Expression of Interest." This will help CMS be able to work your request more quickly. We started accepting these on December 1, 2016, and we will continue accepting them through January 31, 2017. If you are going to be submitting an Expression of Interest, we ask that you please add medicareappealssettlement@cms.hhs.gov to your email security filters. This is the primary email that we use for this process, and we would hate for important documents to accidentally get sent to your spam folders.

Moving on to slide 10. CMS generates a list—this is the next step in the process. Once CMS receives the Expression of Interest, we will generate a list of potentially eligible claims for that hospital. If the hospitals meet the eligibility criteria and have eligible claims, CMS will email a copy of the Administrative Agreement along with the spreadsheet listing claims potentially eligible for settlement. There is a chance that during this process, a hospital may be excluded from settlement based on False Claims Act or other investigations. And if this is the case, a hospital will be notified as soon as possible after we receive the Expression of Interest.

Slide 11. We are going to over hospital validating the list. So, this is the next step in the process. The hospital will receive the Administrative Agreement and eligible claims spreadsheet from CMS. The hospital should review the claims listing spreadsheet for accuracy and verify all eligible claims are included and only eligible claims are included. If the hospital is in agreement with the claims and appeals listed on the spreadsheet, the hospital should sign the Administrative Agreement and send back to CMS at medicareappealssettlement@cms.hhs.gov within 15 calendar days from when they received the agreement from CMS. We request that you reply to the email in which you receive the agreement. And, again, this is just so your response is easier to identify and we can work the documents faster.

Just a quick reminder of something that we've been seeing. Please make sure that you are attaching your Administrative Agreement when responding to this email. We've seen quite a few providers that are applying, but they are forgetting to attach the signed Administrative Agreement. So, just remember to do that. That's going to help things move more smoothly.

If the hospital receives their claim listing spreadsheets and they have discrepancies on it, they should complete an Eligibility Determination Request document. This document can also be found on that Hospital Appeals website. This document allows providers to request to add other potentially eligible claims or remove claims they don't believe are eligible. This document should be sent to CMS within 15 calendar days from receipt of the Administrative Agreement from CMS.

Once CMS receives the Eligibility Determination Request, they will work with the hospital and the hospital-servicing MAC to reach a consensus on the spreadsheet. Once a consensus is reached on the spreadsheet, the hospital should sign the Administrative

Agreement and continue in the settlement process. If the hospital and CMS are unable to come to a consensus on the eligibility of the claims, the provider has the option to move forward with claims that CMS has deemed eligible for settlement and not move forward with the other ones or abandon the settlement process and maintain their appeals.

One problem that we've seen in this process so far—and this was on CMS's end—is that providers were receiving spreadsheets with the same claim number and appeal number listed multiple times on their claim spreadsheet. And this is due to claims having multiple reason codes so they were listed multiple times. Some providers were notifying us of this problem, and that's how we were alerted to it. We have since righted the problem in our system and sent revised spreadsheets to anyone who initially had sent a spreadsheet that had multiple claim numbers and appeal numbers listed. But moving forward, if you're reviewing your spreadsheet and you receive one that has the same claim and same appeal number multiple times, please contact us and let us know. Or you can submit an Eligibility Determination Request to request to have those appeals removed. We are really counting on providers to do a thorough job reviewing these spreadsheets for accuracy.

So, whether the hospital is in agreement and sends back a signed Administrative Agreement or has discrepancies and sends back an Eligibility Determination Request, the hospital should be responding to CMS within 15 calendar days of receiving the Administrative Agreement and claims listing spreadsheet. That's just the really important date to remember. If you're having any problems, we just ask that you stay in contact with us within those 15 calendar days. If you are not in contact with us with either the Eligibility Determination Request or the Administrative Agreement after 15 calendar days, you will be considered to have abandoned the process.

Moving on to 12, the Administrative Agreement. So, the next step will be the finalizing of the Administrative Agreement. And once CMS receives a signed agreement with the hospital's appeals included on the spreadsheet, those appeals will be pended. So they will no longer be worked as part of the active appeals process. And at this point, CMS will also countersign the Administrative Agreement. Once CMS signs the agreement, both the Administrative Agreement and the claims spreadsheet will be sent to the hospital's MAC for processing of final validation and payment.

And, then, slide 13, payment and appeal dismissal.

Payment for settlement will be made within 180 days of CMS's signature on the Administrative Agreement. There will be one single payment made per hospital provider number. If there is a discrepancy in the amounts of the payment or the calculation of the payment, the provider should contact their MACs to sort out any discrepancies. The appeals associated with settlement will be dismissed following payment. There will be

no additional Notice of Dismissal or Procedural Order of Dismissal. The Administrative Agreement will serve as both of these documents.

The next slide we list some resources. We have that HASP website, which is the go.cms.gov/HASP2016. Remember, that's case-sensitive. We have a whole lot of really helpful information there. We have an FAQ document which goes over a lot of the questions that we were asked in the previous settlement process, a bunch of the ones that we've been asked this time and problems that we're seeing—we try to add FAQs to that. It will also have links to the transcripts from these calls and these slides. Our email address for submissions is medicareappealssettlement@cms.hhs.gov. And remember that "appeals" is plural. And, then, if there's any questions, the email address to submit those to is medicaresettlementfaqs – and "faqs" is plural – @cms.hhs.gov.

All right. Thank you very much. That's all I have. At this point, I'll turn it back over to Hazeline.

Keypad Polling

Hazeline Roulac: Thank you, Casey.

In just a moment, we will start the question-and-answer portion of our call. But, before we do, we will pause to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There will be a few moments of silence while we tabulate the results.

Holley, we are 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 currently listening in. If you are the only person in the room, enter one. 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 nine. Again, if you are the only person in the room, enter one. 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 nine.

Please hold while we complete the polling. Please hold while we complete the polling.

And please continue to hold while we complete the polling.

I'll now turn the call back over to Hazeline.

Question and Answer Session

Hazeline Roulac: Thank you, Holley.

So before we start taking questions from our participants today, our subject matter experts will address some of the questions that were received during the registration process. Amanda?

Amanda Burd: Thank you.

As Hazeline mentioned, we're going to just do – we're going to answer some of the frequently asked questions that we received as part of the registration for this process.

Morris, to begin with number 1?

Morris Platter: Okay. Who should be listed as the contact person for the facility on the Expression of Interest form?

Amanda Burd: This is Amanda. And the contact person on the Expression of Interest should be someone that can speak and act on behalf of the provider. This should be someone who is well aware of the settlement and the claims included so that we can contact them with any question. Please note that all of our outreach contact will be made to the person listed as the contact person on the Expression of Interest.

Morris Platter: Will providers be required to wait until after the January 31, 2017, Expression of Interest deadline has passed to begin the process and receive the spreadsheet of eligible claims?

Amanda Burd: No. CMS is sending the eligible providers their potentially eligible claim listing on a flow basis.

Morris Platter: How soon after the Expression of Interest form is submitted will CMS provide us with a list of cases for settlement? If the list comes quickly and the 15-day response period includes the Christmas and New Year's holidays, is it possible to get a short extension of time and review and respond?

Amanda Burd: We expect to provide the listings of potentially eligible claims within 10 calendar days of receiving the Expression of Interest from the provider. As Casey mentioned, if a provider experiences an issue with timeliness and needs additional time, please contact CMS via email as soon as possible. The provider should reply to the email correspondence from CMS containing the Settlement Agreement and claims listing spreadsheet regarding this issue. This makes it much easier to track.

Please note that a provider that is not responsive during the 15-day timeframe will be considered to have abandoned the process – meaning within that 15 days, we ask that you communicate with us and with the hopes that at the end of the 15 days that you have submitted a signed Administrative Agreement or an Eligibility Request Determination. Please note that CMS will attempt to follow up with providers at least once before this happens. However, we do really request that providers communicate with us. Thank you.

Morris Platter: If I have submitted a request for an ALJ or Medicare Appeals Council and I now desire to enter into the 2016 Hospital Appeals Settlement, does a provider need to notify these levels by submitting a request to withdraw the appeal or will it be automatically placed on hold and these two levels be notified by CMS?

Amanda Burd: Each provider may determine how it wishes to handle its scheduled hearings on an appeal-by-appeal basis depending upon the timing. If the provider chooses to pursue the Hospital Appeals Settlement option and wishes to postpone a scheduled hearing, please contact the ALJ team assigned to your hearing and request a continuance in writing. To request a continuance in writing, we ask that that correspondence states that you are requesting a continuance while you pursue resolution via the CMS Hospital Appeals Settlement to the ALJ team assigned to your case and send copies of that correspondence to all parties. Contact information for the ALJ team assigned to your appeal is available on the notice of – on the OMHA website through the ALJ Appeal Status Information System. And you can find that using either the QIC or the ALJ number. So, that's what happens while – before your sign the Administrative Agreement.

If you choose to pursue the Administrative Agreement, once your Settlement Agreement is signed and submitted to CMS, the appeals will be pended. And that means that that information will be shared between CMS and OMHA. When an appeal is moved into a pended status, the ALJ team will not be able to process the appeal any further and no hearing will be conducted.

If a provider finalizes a Settlement Agreement with CMS, they agree to have all their eligible claims dismissed from the appeals process. And the finalized settlement agreement serves as both the provider's withdrawal of the eligible claim appeals and also the dismissal of the resolved appeals from OMHA or the DAB. No additional withdrawal or dismissal documents will be needed or provided. Thank you.

Morris Platter: If we do ultimately sign a settlement and there is a discrepancy when the settlement amount is provided to us compared to the net payment amounts we show in our records, how can we resolve this discrepancy?

Amanda Burd: As part of the final payment, you will receive an accompanying spreadsheet which lays out the factors that went into calculating the payment. If there

is an issue and you believe that there was a miscalculation on a claim appeal specific to the allowed/allowable amount, we recommend that you contact your MAC in a timely fashion. The MACs can then review the accuracy of the calculation of the net allowed/allowable amount.

Morris Platter: Eligibility. Can providers that participated in the previous settlement also participate in the new settlement? CERT auditors have continued to audit claims for status since 10/1/2013 date, and some providers have findings pending an ALJ hearing.

Amanda Burd: If a provider still has eligible claims remaining, that provider may participate in settlement. All claims must meet the eligibility criteria.

Morris Platter: Is a distinct unit for psychiatric patients within an acute care hospital considered exempt from the settlement?

Amanda Burd: Eligible claims under appeal by the acute care and the critical access hospital unit may be submitted for resolution through this process as those are considered eligible provider types. Claim appeals involving other distinct units are not eligible for this resolution.

Morris Platter: The cases we have requested ALJ hearings for are in various statuses: received, not assigned, assigned, scheduled, in deliberation, etc. Please address which of these statuses qualify to be included in the settlement.

Amanda Burd: As long as a decision has not been rendered on the appeal as of the date the provider signs the Administrative Agreement, the appeal and the associated claims are eligible for settlement. At the time that the provider signs the settlement agreement, appeals will be pended and taken out of the ALJ -- the active ALJ workload.

Morris Platter: Will prepay Recovery Auditor Contractors, or RAC, appeals be eligible?

Amanda Burd: Yes. RAC denial, prepay or post pay, are eligible as long as the claim type – as long as the claims meet all other eligibility criteria. The payment will be equal to 66 percent of the net paid or payable amount plus coinsurance and deductibles.

Morris Platter: During the last call, it was mentioned that the interest initially recouped after the QIC denial would be paid back to the facility. Is that accurate?

Amanda Burd: Yes. Any interest paid by the hospital after the claim was denied will be refunded.

Morris Platter: If a settlement is taken, must settled cost reports be refilled—filed?

Amanda Burd: For those, claims will remain as denied in the CMS system and will not be included for cost report purposes. Therefore, the cost report does not need to be re-filed.

Morris Platter: Is CMS considering settlement options for other provider groups as well?

Amanda Burd: CMS continues to explore all options for similarly situated claims and claimants. The Department of Health and Human Services, meaning the Department, remains committed to resolving the Medicare appeals backlog as expeditiously as possible. The Department has a three-pronged approach to improve the Medicare appeals process. First, invest new resources at all levels of appeals to increase adjudication capacity and implement new strategies to alleviate the current volume of pending appeals. Second, take administrative actions to reduce the number of pending appeals and encourage resolutions of cases earlier in the process. And third is propose legislative reforms. Please review the Office of Medicare Hearings and Appeals websites for information on the Settlement Conference Facilitation Pilot as a potential option.

Morris Platter: For hospitals that want to settle claims denied by the Office of Inspector General, or OIG, that are the basis for extrapolation, does CMS have a process set up to formally confirm with OIG the status of the settled claim?

Amanda Burd: CMS does not have a process set up with the OIG. If a provider wants to include claims in a settlement that were part of an extrapolation, only the actual denied sample claims can be included. The extrapolated universe of claims that was not actually reviewed and denied can't be included, meaning that the claim itself must actually be denied to be included in the settlement. If a provider would like to determine the effect that the settlement would have on the extrapolation, the provider should reach out to the OIG representative that they have worked with.

Morris Platter: In regards to sole community hospitals, will the discharges show on the Provider Statistical and Reimbursement System, or PS&R, for the cost settlement?

Amanda Burd: The claims will remain denied and, therefore, there is no effect on the PS&R.

Morris Platter: Please discuss if hospitals do not have to pay back any money already received from secondary payers, deductibles etc.

Amanda Burd: If the claim is included in the settlement, the provider will receive 66 percent of the net payable amount, although the claim will remain denied in the CMS system. A provider's obligation to other payers will be determined by the existing laws and/or the provider's existing agreements and arrangements with those other payers governing these situations.

The provider's refund responsibility is as follows. One, if the beneficiary's coinsurance has been collected at the time that CMS signs the Administrative Agreement, no refund is required. Two, if the beneficiary's coinsurance has not been collected at the time CMS signs the Administrative Agreement, the provider must cease collections. If a beneficiary's repayment plan has been executed at the time that CMS signs the Administrative Agreement, the provider may continue to collect the coinsurance in accordance with the repayment plan.

Morris Platter: The FAQ sheet indicates that if a provider accepts a settlement, then the settled denied claims will not be factored into any future Additional Documentation Requests, ADR, limits. Can you please confirm this FAQ?

Amanda Burd: Yes, we can confirm the FAQ. Settled claims will not be used in any calculations to determine a provider's denial rate for the purposes of establishing ADR limits.

Morris Platter: We have withdrawn some appeals to rebill and have not received confirmation that the withdrawal is complete from OMHA—O-M-H-A. If these appeals are listed on the document provided by CMS, will there be an opportunity to correct the list before agreeing to the settlement terms?

Amanda Burd: Yes. When you receive your eligible claim listing from CMS, we ask that you review the listing of claims for – to verify that these claims are, in fact, eligible for the settlement. If you do not believe that a claim is eligible for the settlement, you should submit an Eligibility Request Determination. We ask that on this specific example where you believe that you have already attempted to rebill it that you do let us know that that is part of the problem, that these are – you're trying to remove these claims because you have rebilled. This allows us to get the information to the correct people. So, a little background and history, when you provide it, is always greatly appreciated.

Morris Platter: Why is CMS only allowing 66 percent and not the 68 percent as previous in the 2014 settlement?

Amanda Burd: The 2014 Hospital Appeals Settlement was intended in part to alleviate the administrative burden of the current appeals on both the provider and Medicare. For those providers who did not take advantage of the settlement in 2014, the Department had to incur administrative burdens for the appeals that remained in the system.

Morris Platter: Why is the eligible ending date of service the same as the prior settlement? Why not extend the eligibility period to reduce the backlog?

Amanda Burd: This settlement is similar to the one that was offered in 2014. As stated in the 2014 Hospital Appeals Settlement, CMS believes that changes in the final rule

1599-F, which was published in August of 2014—the so-called Two-Midnight rule—will not only reduce improper payments under Part A but will also reduce the administrative costs of appeals for both hospitals and the Medicare program. Therefore, to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS created an Administrative Agreement for hospitals willing to withdraw their pending appeals for exchange – in exchange for timely payment for claims with dates of service prior to October 1, 2013, that meet all eligibility criteria. Thank you.

Hazeline, that was the end of our prepared Q&A.

Hazeline Roulac: Thank you, Amanda.

We want to thank everyone who submitted questions in advance of today's call.

We will now take calls from our participants. I want to remind everyone that this call is being recorded and transcribed. Before we – before asking your question, please give 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 question to just one. If you would like to ask a followup question or have more than one question, you may press star, one to get back into the queue, and we'll address additional questions as time permits. All right, Holley. We are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone 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.

Our first question comes from the line of Jill Robinson.

Mary Myslajek: Hi. This is Mary Myslajek from Hennepin County Medical Center in Minnesota, and I have one question. You mentioned that CMS does not believe there are any appeals pending at the second level, at the QIC level, for cases that would be eligible. If a hospital does have cases at the second level, do we need to do anything special to confirm that for you, or will you find them? Because we do have cases pending.

Casey Welzant: Hi, Mary. This is Casey. So, if that is the case, they probably will not be on the claim listing spreadsheet that you get from us because we pulled data from Level 3s and Level 4s. So, what you'll need to do is submit an Eligibility Determination Request. And, then, if you have any proof that it's still pending at Level 2 that you can submit that along with the Eligibility Determination Request, that would really help us expedite verifying that information for you.

Mary Myslajek: Okay. And what would the corresponding information be that you would want to have? I mean, we were accepted by the QIC. We've submitted them and they haven't given us a determination yet. So, would you need something from the QIC to confirm it, or will you – if we give you the relevant account information, would you go out and confirm it with them? Because they don't send us an acknowledgment immediately.

Casey Welzant: Okay. If you could send us the QIC appeal number with your Eligibility Determination Request, that would be very helpful.

Mary Myslajek: Great. Thank you very much. I appreciate it.

Casey Welzant: Thank you.

Operator: Our next question will come from the line of Pam Pyle.

Pam Pyle: Hi. My name is Pam Pyle. I'm a nurse and I'm calling from TriHealth in Cincinnati, Ohio. We submitted our Expression of Interest forms on December 1st. We have received our spreadsheet of eligible claims. There was discrepancies – the report – discrepancies which are being handled. There's not a signed Administrative Agreement at this point because our attorney is taking care of that.

The question that I have is on Thursday, the 8th of December, we had an ALJ hearing, and the judge gave us the determination which was favorable at the time of the hearing. That case was within the spreadsheet that CMS provided to us. We're not quite sure what to do. We have a favorable outcome. We don't have the letter – outcome letter from the judge yet. Where does that case – that claim stand in this whole Expression of Interest and settlement situation?

Amanda Axeen: Hi, Pam. My name is Amanda Axeen. I'm another Amanda on the call here. And I'm actually with the Office of Medicare Hearings and Appeals. So, I can try to speak to that. The ALJ's decision needs to be written. It can't just be an oral decision from the bench like that. But, if you do receive a favorable decision before your settlements – before your Administrative Agreement is signed with CMS, the decision will be effectuated as usual and you would get full payment for that decision, so – or for that underlying claim under that appeal. So, it really just is a matter of the timing on that. Right?

Female: (Inaudible).

Operator: All right. Our next question will come from the line of Elizabeth Bowling.

Elizabeth Bowling: Yes. This is Elizabeth Bowling in Warm Springs, Georgia. We're a rehab center, and we thought until this presentation, until the handouts, that we would

be eligible. Do you – we probably have 10 or 11 that are waiting to be assigned to an administrative law judge. Do you see something coming soon for rehab hospitals?

Amanda Burd: Again, the purpose of this call is to discuss the Hospital Appeals Settlement. There may be resources available for your facility on the OMHA website regarding the Settlement Conference Facilitation. Thank you.

Operator: Our next question will come from Karen McKenney.

Karen McKenney: Yes. Hi. Good afternoon. Yes. Hi. Good afternoon. I just had a question regarding – we've received recently quite a few denials at the administrative law judge level, and we are considering moving forward to the DAB and have not made a decision as far as the settlement goes at this time. So, what happens to claims that you're moving forward with that might be kind of in between? Would it be considered ineligible because it was denied at the ALJ before it received a hearing date at the DAB is my question?

Casey Welzant: No. Those claims would still be eligible. So, the eligibility criteria is they were currently pending at the ALJ or the council level or that they're within the timeframe to appeal. So those would definitely fall within the timeframe – within the 60 days. So, you can still move forward with the appeals at the DAB level concurrently with adding those into settlement. And once – if we do reach settlement with those appeals, they will be dismissed. So, I think that would be the best course of action.

Amanda Burd: One note just to make is that those claims that are pending to go – that are still eligible to be appealed to the next level – you may not see those claims listed on your spreadsheet because the spreadsheets are pulled at a point in time. So, if it's not – if it's still within its timeframe to appeal, we just don't see it on our books. You will need to add that in through the Eligibility Request Determination process. So, it's certainly something you can do. Just be aware that it may not show up on your list. And that's what the Eligibility Request Determination process is for.

Hazeline Roulac: Thank you. Next.

Operator: Our next question will come from the line of Anne Davis.

Anne Davis: This is Anne Davis from Community Hospital at the Monterey Peninsula. My question is how might the settlement affect EHR or HIT payments that are based on Medicare dates?

Amanda Burd: These claims will remain denied in the Medicare system and, therefore, there is no effect on the cost report.

Hazeline Roulac: Okay. Thank you.

Next question.

Operator: Our next question will come from the line of Megan Evans.

Megan Evans: Yes. We're calling from Starkville, Mississippi. If you have a discrepancy, it says to contact the MAC as far as the calculations? At what point will we get the calculations? Is it at the time of payment or prior to?

Casey Welzant: You will receive your calculation -- it will either be concurrently or immediately following payment that you'll see the spreadsheet that'll list all the different – what factored into the payment amount.

Megan Evans: And what if we can't resolve it with the MAC? What's the next – where do you go from there?

Casey Welzant: If there – if you can't come to a concurrence with the MAC, CMS may be involved down the line. But we will kind of cross that bridge when we come to it. We're hoping that nothing will come to that point.

Operator: Thank you. I'll now turn today's conference over to Hazeline Roulac.

Additional Information

Hazeline Roulac: Thank you, Holley.

We want to thank everyone for participating in today's call. If we did not get to your question, you can email it to the address listed on slide 14 of the presentation.

If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will place an announcement in the MLN Connects Provider eNews when these resources are available.

On slide 17 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Hazeline Roulac. I would like to thank our presenters and thank you, our participants, for joining us for today's presentation on the 2016 Hospital Appeals Settlement Update Call. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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