



**MLN Connects™**

**National Provider Call Transcript**



**Centers for Medicare & Medicaid Services  
Hospital Appeals Settlement Process  
MLN Connects National Provider Call  
Moderator: Mark Korpela  
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**Operator:** At this time, I would like to welcome everyone to today's 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 Mark Korpela. You may begin.

## Announcements and Introduction

Mark Korpela: OK, thank you. Hello everyone. Thank you for joining the call today and thank you for your participation in the Hospital Appeals Settlement Process. As Victoria stated, my name is Mark Korpela, I'm with Centers for Medicare and Medicaid Services in the Office of Financial Management. And I'll be doing the presentation today.

At this point, all of you are either currently in the Round 1 process or that process has already been completed, meaning you've already received payment for Round 1. The purpose of today's call is to walk you through the Round 2 process, and then afterwards we'll have time for some questions.

When you received an email from us — from our contractor — attached was a document that was called the Critical Steps document. I'll be working from that today, not word for word, but I'll be using that as a base. So, hopefully, you have that. If you don't, you know, I'll be going through the process so you'll be able to ask questions, you'll be able to take notes. A transcript from this call will also be posted to our website at a later time, so you'd be able to get information from there.

If you have any questions at all about the process, you may email our — what I'm going to refer to as the CMS email address throughout this call. It's in the document and it's on our website. Many of you may have used it before; it's MedicareAppealsSettlement, and that would be all one word, [medicareappealssettlement@cms.hhs.gov](mailto:medicareappealssettlement@cms.hhs.gov). Again, if it's something that we can't answer today for you, please email that email address and we'll be able to answer you.

## Presentation

So as for the settlement, we broke this into what we call two different rounds. And the reason was to have — the reason for having two rounds was so that we could initially agree on claims with you as the hospitals and get a payment out to you for those initial claims. Again, that was to speed up the process, so the payment could be made.

Round 2, the process would be to finalize everything, including any claims that were not included in Round 1. So however you want to refer to it, Round 2 is basically the final process — trying to finalize the settlement process. After the Round 2 process is completed, any appeals for claims not in the settlement will be resumed, which we'll talk about in a little while.

So, again, I'm going to talk from the Critical Steps document. If you have that with you, that document refers to Round 1 and then Round 2. The Round 1 piece — hopefully, all of you have already been through or are in process, so I'm not going to walk through that.

### **The Round 2 Process**

But we start with Round 2, noting that if a provider has a list of disagreements, and what we mean by disagreements is that if you have any claims that weren't resolved in Round 1 because there was an issue, whether it was eligible or not eligible for the settlement. So I'm just basically going to walk through the process; and again, we'll take some questions later.

So, when Round 1 is completed, you'll have claims that weren't included in Round 1, so that's where we're saying provider reviews the Disagreement spreadsheet and adds comments, as needed, to the Narrative Note column.

At that time you'll be sending in your Round 2 Settlement Agreement and the claims listing. So that claims listing would be the claims that weren't included in Round 1, along with your notes of anything that you want to explain of why that should be eligible or ineligible. And send that to what I'm, again, calling our [CMS email](#) address.

It works better for us to have a consistent file name and email address line, so you'll see in that document that we've given you the recommended file names. And I also ask whenever you send in an email to that email address that you clearly identify what the email is in the subject line. It makes it much easier with — just with all of the emails that come into that box, it's much easier to organize for us and allows us to answer you more promptly.

After the — you send in the Settlement Agreement along with the document, it is actually sent. We receive it in our [CMS email](#) address. We distribute it to the Medicare Administrative Contractor that you work with, and that MAC, as we call them, is the one that processes your claims and cost reports.

The MAC will then review the documents that you send in, including all the notes that you have. So they're going to take that list and they're going to review your notes, but they're also going to compare it to their Round 1 list to see what claims they have left over. So if you have claims that were included that they haven't seen before, they're going to obviously identify those. If they have claims that you didn't include at that point, they will add them to the list. Basically, it's your list coming into the MAC, and then the MAC determining if all the claims are there.

## **The Round 2 Spreadsheet**

We've asked our MACs to create a total of four tabs on that spreadsheet. When you send it in, it's one tab, we're calling that the Master tab. From that, we're having them copy the claims to three different tabs for — and you'll see in a while why we're doing this:

- The first tab would be Eligible Claims-Agree. So basically those claims are the ones that both you, as the hospital, and the MAC agree are both eligible for settlement.
- The next tab would be Ineligible Claims-Agree. That's where both the MAC and you, as the hospital, agree that they're ineligible for settlement.
- And then the last tab is what we're calling Unresolved. If applicable, we have in the document.

All the claims are going to be copied to one of those tabs, but they're also going to stay on the Master tab. Again, you'll see why in a couple of minutes.

So at this point in the process, there's two different scenarios that can happen. If — hopefully, at this point, which may or may not happen, there will be no Unresolved tab, meaning that both you and the MAC agree to all the claims as both being eligible or ineligible. So I'm going to talk about that one first, if you're using the Critical Steps document, it's actually step 5.

## **For Providers without Any Unresolved Claims**

Those claims, at that point, because everyone agrees, will be priced by the MAC. They will price them similar to what they did in Round 1, where they actually, for a post-pay claim, they will obtain the amount that was denied. If it was a pre-payment denial, they will calculate what would have been paid.

At that point, they lock the spreadsheet because they want you to see a locked spreadsheet so it cannot be manipulated. Also, at the bottom of that spreadsheet, you will see a total. That would be the payment amount for Round 2. The column on the spreadsheet is CMS Net Settlement Amount. At that point, CMS would sign the Administrative Agreement.

CMS would also send the provider through our email — that email box that we were talking about — an email indicating that the second agreement has been fully executed, meaning that we've signed here at CMS, and the MAC will be notified to begin processing the Round 2 payment. That email will have the claims list that we discussed and the fully executed Administrative Agreement, again, signed by both you and us — the final agreement.

Similar to Round 1, prior to processing the payment, the MAC will send you a payment notification email. Normally what happens is that email is sent at the time that they're entering the data and the information into the system for payment. So you should see payment within a week or so. Again, it's processing time through our systems to get the payment to you on the Medicare remit.

At that point also, dismissal letters will be sent for the impacted Round 2 appeals. That we'll talk about in a little — in more detail in a little while. All claims that were pended that weren't included in Round 1 or Round 2 will be reinstated. Again, we'll talk about that at the end.

So that — again, that's the easier scenario. That's basically saying that both you and the provider agree on all the claims that were initially sent in by you and what they added as valid — in the validation stage.

#### **For Providers with Unresolved Claims**

We understand that there will be disagreements. There could be where you have additional documentation that could support a claim that's either eligible or ineligible. So then we go to step 11, for those providers with an Unresolved tab, which we expect there will be quite a few just because there could be additional documentation needed.

When we say Unresolved tab, again, that means that there's claims that have not been fully agreed upon between you, the hospital, and the MAC on their eligibility for settlement.

The MAC will email the modified spreadsheet with instructions for supporting documentation for — supporting documentation submission. Meaning that they are going to send you that Unresolved tab. In the column, they're going to include some information for you on why it's not eligible, and if there's something you could send to support that it is eligible, they're going to include that there.

You may have documentation they're unaware of, so you'll have the ability to send that. And there's multiple reasons why the MAC might not have the same information you have.

Those instructions you receive from the MAC will explain to you how they want the data transmitted. Because some of those have PHI on it, we have to ensure that it's protected. So, they may ask you to fax it, and if so, they'll give you a fax cover sheet and a form to use. They may ask you to email it, and if you do email it, they're going to talk to you about the encryption process, or if you encrypt it, please work with the MAC so they are able to unencrypt it, because I know in Round 1, both you as the provider and the MAC both had issues with encryption because there's so many different software

packages out there. And a note in here, again, the reason for this is because we have to protect the PHI that submitted, so it has to be encrypted somehow.

Once the MAC has received that documentation, they're going to email you just to acknowledge that they received it. So if you send them something, we've told the MAC that they have to confirm receipt from you, so you will receive an email.

They're going to get that documentation and review it to ensure that — well, to determine what your statement is, to determine if it's eligible or not eligible based on the documentation. The goal of this is to get to a point that there's no claims remaining on that Unresolved tab. But we understand going back and forth with you and the MAC, there could still be discrepancies, so we're going to talk about that in a minute.

If at that point there are no discrepancies, meaning that you've reached consensus on all claims, the process is going to continue to what we talked about before, where they're going to price it and pay it. So then they would price it, send you the information. They would enter the payment information, all of that, so you could be paid within that week.

If there are still unresolved claims at that point, the MAC will contact you as the provider, whoever your point of contact is. And they may request, again, more information. Hopefully, you'll have information to go back, you know, go back to the MAC and resolve that. If there isn't a consensus met between you and the MAC, they will be sending that to us here at CMS, and we will review it.

At the end of the day, then, agreement has been signed and all claims that are in this category of patient status denials are to be included in the settlement because we already began the process. So we at CMS will make that final decision, whether it's eligible or ineligible, and then you will be notified of that decision. So after that process is completed here at CMS, if there are unresolved claims, you will then have what we consider an Unresolved tab that's empty because all claims would have moved to either the Eligible or Ineligible tab.

And at that point, if there's any questions — I mean, we're hoping everything would be resolved — if you have questions about the eligibility, you'll continue to work with your MAC on that process. If there are questions about the process, you can send them into that general [CMS email box](#) that we talked about.

We have a statement in here at 18 that all settled claims are subject to additional review at a later date to verify eligibility to be included in the settlement. That's in the agreement that we have the ability to go back, to ensure that all claims are proper in the agreement. So, hopefully, this won't happen often, but there are chances that claims could be changed at a later time because additional information is identified for various reasons.

So when we complete that part, and the unresolved piece — the unresolved claims are taken care of, we then go back again to what we talked about earlier, which was step 7, which would be the payment process.

### **At the End of the Process**

So, in all of these scenarios, at the end of this, there will be no claims on that Unresolved tab, you will have a final list of eligible claims and ineligible claims. The eligible claims will be those that are paid, the ineligibles are those claims that are not eligible for settlement and, therefore, at a later time, the appeals can be reinstated.

That information will be sent to the appeals entities that currently have the appeals so they can restart the appeals. So, again, some claims have been restarted already after Round 1. We're aware of — but for the most part, after Round 2 is completed is when most of that is going to happen because then we have the final list.

I just want to make you aware of a couple of other processes here. Working with Round 1, some of you may have already received a Round 1 payment, and you may have seen something that your MACs call the payment reconciliation. Because in the payment process, data has to be entered, and there's various issues such as accrued interest or interest that we're paying back to you as part of the process, we are having the MACs go back and reconcile the payment. So there is a chance, if you haven't seen it already, that after that payment is made, there could be slight variances between the final payment and that initial payment. And that is because in the financial system, they have to go in to ensure that all the interest is accounted for properly, that you received all your paid interest back, and the current interest is adjusted off and any other issues that are in there with the payment.

So there — you know, within a month or two after your initial payment, there is a chance for reconciliation. And if anyone has any questions, we can come back to that part later.

Any time we adjust the payment for any reason, the MAC would contact you. So you should receive emails from the contractor if they reconcile the payment for any reason.

There also are chances that there were claims excluded or included or calculated incorrectly, so there could be instances there. Again, this is not to try to add new claims or delete claims that were on the list. It's merely to fix the payment amount so you get the accurate payment.

Also at the end of the process, we have something that we refer to as a claim reconciliation. That's where the MACs will work with all the appeals entities to ensure that all of the claims are — that are paid as part of the settlement and have their appeals properly dismissed and also ensure that the ineligible claims in the settlement are identified so they can be restarted by the appeals entity.

So, again, when all of this is completed, we're going to have — we're going to go back to double check to make sure we've captured everything we needed to. The goal is to have — if you're in the settlement, the goal is to have any appeal in this category of patient status denials included in the settlement and anything that is not in that category not included in the settlement, so then the claims can be restarted.

## Additional Information

In a few minutes, we'll begin to take some questions. Again, I said it earlier, please remember, if we can't answer the question on the call today or if you have any additional questions after the call, please send them to that email address, [medicareappealssettlement@cms.hhs.gov](mailto:medicareappealssettlement@cms.hhs.gov).

Many of you have seen emails from this box, and you'll see the name Santiva on there. Santiva, just so you're aware, is our support contractor. So, it's very possible that when it's signed from that email address, if you get an email, it's signed by Santiva. They are our direct support contractor, so they handle our processing. And they also ensure that the proper questions make it to the proper people. So, again, a reminder, please include email subject lines on those emails so we know where the question should go.

I've addressed Round 2 at a high level. I really have walked through the Critical Steps document at this point. I don't have anything else to share in the process. So, Victoria, I think we're at a point that we can take questions.

## Question-and-Answer Session

**Operator:** Certainly. 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 into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Marsha Niknik.

Marsha Niknik: Thank you. My question was about number 11. For providers with an Unresolved tab, they're going to send us an email saying that we — you need more information. It doesn't say on there how many days we have to turn that information around. Is there a deadline that we have to meet?

Mark Korpela: Sure, this is Mark. Generally, we request within the 14-day window, just like we did for Round 1. If there's any issue — if there's any questions, if that's an issue, you can always work with your MAC on the response time.

Marsha Niknik: OK.

Mark Korpela: But generally, when we ask for a provider response, unless specified differently, it would be 14 calendar days.

Marsha Niknik: And how soon are we going to be getting these emails with the various tabs — are they, like, ready to go?

Mark Korpela: Well, I'll explain that. Originally, when we started Round 1, we had requested that you, as the provider, submit everything within 14 days for Round 2. Just for various reasons and so many settlements to process, we want to ensure Round 1 was taken care of properly. So we held back a little on Round 2.

So the MACs will be starting Round 2, like, any day now. So I would expect within a month, you should all start seeing your Round 2s coming back.

Marsha Niknik: Thank you, that was very helpful.

Mark Korpela: OK, thanks.

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

Ann-Marie Carducci: Hi, you said you were going to address the issue about the MACs sending dismissal letters, because we had our settlement in December and we haven't seen any dismissal letters yet. Can you address that?

Mark Korpela: Sure. So your settlement was in December. Did you have any claims remaining that were ineligible or discrepancies, or was everything agreed upon?

Ann-Marie Carducci: No, I have 31 Round 2 cases.

Mark Korpela: OK. So two things that can happen there. If they were 100 — if we were comfortable that it was 100 percent complete at that point, and no additional information was needed, information would have been sent to start the process on the appeals. But because there's claims remaining for Round 2, we wanted — before we either closed appeals or restarted appeals, we wanted to make sure everything was proper. So we wanted Round 2 to be completed.

So if you have a Round 2, it's most likely the claims are going to be held until that point — until that Round 2 is complete, hopefully ...

Ann-Marie Carducci: OK.

Mark Korpela: ... that makes sense the way I'm saying. It would have been — ideally, it would have been faster if we restarted them now, but we didn't want to restart appeals and then find out later they were eligible. So we're holding as much as possible until the end to make sure everything's proper.

Ann-Marie Carducci: OK, so after Round 2, it seems like you're saying after we complete Round 2, then all indicated dismissal letters will be sent to us.

Mark Korpela: Yes.

Ann-Marie Carducci: OK, thank you.

Mark Korpela: The difference with that, because there could be other questions — if we and the MACs are 100 percent sure, I should have stated this sooner, if they're 100 percent sure that there is nothing for Round 2.

Ann-Marie Carducci: Yes.

Mark Korpela: And that also includes an email. Our contractor, Santiva, was sending out emails to all of you that didn't receive a Round 2, just to make sure there was a Round 2. If by chance at that point, we're 100 percent sure there's nothing left, the claim restarting could start then, but for the most part, it's Round 2.

Ann-Marie Carducci: All right, thank you.

**Operator:** Your next question comes from the line of Janet McKay-Denna.

Janet McKay-Denna: Hi, this isn't really a process question, but many of my Round 2 claims are claims that started as DRG denials, and then when we appealed, they became medical necessity denials. And you guys originally denied them, saying they weren't part of the scope, but based on the first appeal decision, that made them medical necessity denials; I think they are in scope. Have you seen that from any other providers, and what's your position on that?

Mark Korpela: Yes, we have seen that quite a few times. They are — they are patient status denials, even if ...

Janet McKay-Denna: Right.

Mark Korpela: ... it started as a DRG, so they should be in the settlement. Is your question that they should or should not or ...

Janet McKay-Denna: My question is, they should be. So as long as you're — we're — you know, we're still looking at that and you've seen it with other providers, you just gave me the perfect answer.

Mark Korpela: Yes, so I will add that it is possible when the MAC first looked at it, they may have seen a DRG denial, and you may have something they don't.

Janet McKay-Denna: Yes, that's perfectly understandable. And some of the decision letters are very difficult to read. So I can — as long as we're working together. I think you guys have been really well organized and communicative and it's working well.

Mark Korpela: All right. Well thank you for saying that.

Janet McKay-Denna: You answered my question. Thank you.

Mark Korpela: Yes, the goal is to get all of the patient status denials in the ...

Janet McKay-Denna: Right.

Mark Korpela: ... agreement. OK, thank you.

Janet McKay-Denna: Thank you so much.

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

Karen Robinson: Good afternoon. My question is, when we received our Round 1, we also received a spreadsheet for the disagreement. At that time, within the 14-day interval, we did send it. Didn't have those extra tabs available, so are we go — should I expect to see another spreadsheet come back, or do you think you'll be working with what we sent?

Mark Korpela: No, so ...

Karen Robinson: What I did, I kind of did on my own, I took — I did a cut and paste onto another sheet on that particular spreadsheet and made our opinion — or our information on that sheet. So how will it work from here?

Mark Korpela: Right. So you did it properly, and, hopefully, I stated it that way, maybe I didn't. But the MAC is the one that's going to add the tabs, not you as the provider. So you sent in the disagreements exactly the way that I explained it. What you did was proper.

You sent it to the MAC. The MAC will then review it, and then they will add claims if needed or what — delete claims or — then they'll move claims to the different tabs. So you'll receive that back from the MAC. What you did was OK.

Karen Robinson: OK, thank you very much.

Mark Korpela: Bye.

**Operator:** Your next question comes from the line of Mike Selino.

Mike Selino: Hi Mark. I have a question about when we get that list back from the MAC containing those four tabs that you mentioned. If in case a claim is under the Eligible Claim NA, then we find out that the claim has been overturned, let's say, in this — in the reconsideration level of appeal, could we move that claim over to the Unresolved to — for it to be closed?

Mark Korpela: So — I need to make sure I understand it.

Mike Selino: Um-hum.

Mark Korpela: So you received a determination, a claim decision ...

Mike Selino: Um-hum.

Mark Korpela: ... after the claim was already in the settlement?

Mike Selino: Yes.

Mark Korpela: OK. So we've heard of this happening.

Maria Ramirez: Correct.

Mark Korpela: And Maria Ramirez can add to what I start here, is that any claim that was originally in the settlement at the time the settlement was submitted remains in the settlement. If by chance a decision was rendered by one of the appeals entities, that will not be effectuated. It will remain in the settlement.

So I'm not sure if I'm answering your question. It would remain — that claim would be eligible for settlement in this. And I know that it gets — sounds interesting because you received a decision on a claim, but because it was already in the agreement, it stays in the agreement. Maria, is there anything you want to add to that?

Maria Ramirez: That is exactly accurate.

Mark Korpela: So I'm not sure in your question — what tab you said it would go to, but in that, it would remain eligible if it really was a patient status denial.

Mike Selino: So what could we do with the — so we would be paid twice, or I don't get it, because the same ...

Maria Ramirez: Yes. So that claim's essentially will be — just be, like, set aside or not effectuated. It will be effectuated through the settlement process.

Mike Selino: OK, so we would be agreeing that it would be in the Eligible Claim tab, right? I mean ...

Maria Ramirez: Correct.

Mark Korpela: Yes, yes. Now, you may not agree to that when you send it in. The MAC should be putting it there though, because it would be an eligible claim. Do we have — so everyone on the call is aware, we are aware that some determinations were made after claims were put into the agreement for various reasons. And, unfortunately, that happened in some cases. But once the claim is in the agreement, it is part of the agreement.

Mike Selino: All right, thank you.

Mark Korpela: OK, thanks.

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

Lauren Hopper: Hi, I just have a quick question. We have a lot of claims that were never eligible for the settlement, that we did not include in any of it. They're all DRG denials. While we were in the appeal process during the settlement, specifically the issue is with the QIC, with MAXIMUS, they are saying that because the providers had settled, these cases are currently not part of the appeals process, and if you look in Q2A, it indicates that the QIC has deleted the cases.

We've been told various times over the last 3 to 4 months that the cases should be re-reviewed soon. They should be put back in the process because they're DRG denials. Do you know when those cases should be put back into the actual appeal process and, say, were never ever a part of our settlement submission?

Maria Ramirez: Hi, this is Maria Ramirez. If you'd please send your contact information to the [settlement mailbox](#), we will make sure that the AdQIC puts those claims back into the process.

Lauren Hopper: Should I include the claim information or just my contact information?

Maria Ramirez: If you have a list of claims that you want to go ahead and submit, that would make things a lot easier.

Lauren Hopper: OK, all right.

Maria Ramirez: Thank you.

Lauren Hopper: Thank you.

**Operator:** Your next question comes from the line of Plethona Wiricken.

Plethona Wiricken: Good afternoon. So my question is that we have, like, 13 facilities still waiting for the Round 1 payment. So I'm concerned about when will we receive the confirmation for these facilities?

Mark Korpela: Sure. There are Round 1 payments still in process for various reasons. If you'd like the status, I'd suggest you send it to that [email address](#). And our contractor, if it's something very easy to answer, they will reach out immediately. If it's something they need to send to me here, they will. But, if you send that in, we'll be able to respond pretty quickly to you.

Plethona Wiricken: Yes, but we still did not receive the confirmation emails even with some ...

Female on the participant line: We did not receive the agreement and the disagreement sheets as well. So we did not receive any information from our MAC, for all of these 13 facilities.

Mark Korpela: Right, so there's various reasons why that could happen, and I can't go through them all on the phone. I need to see the actual 13 facilities and I could be able to answer you directly.

Female on the participant line: Um-hum. So we already submitted quite a few emails to the email address that you've mentioned, the [medicare@hhs.gov](mailto:medicare@hhs.gov). But we haven't heard back from anyone yet. Is there like another email that we can send our questions and concerns with the list of the NPIs?

Mark Korpela: Let me have you do this. Send it to that [email address](#) and put "Per National Call," or if you just want to put the name "Mark" in there, and I'll make sure Santiva sees that and I get it as fast as possible.

Female on the participant line: Can I just say "Attention Mark" on the subject line along with the question?

Mark Korpela: That'd be fine, yes. Do that and then they'll be aware. They're probably on this call also, so they're hearing that. So I'll get it as soon as possible.

Female on the participant line: So can you please confirm the email address once more, just in case?

Mark Korpela: Sure. MedicareAppealsSettlement, make it all one word, no spaces between. So it's [medicareappealssettlement@cms.hhs.gov](mailto:medicareappealssettlement@cms.hhs.gov), G-O-V.

Female on the participant line: OK, sure. Thank you so much Mark.

**Operator:** Your next question comes from the line of Christina Lucas.

Christina Lucas: Hello? Hello?

Mark Korpela: Yes, we're here.

Christina Lucas: Hi, thank you for taking my call. We were also one of the hospitals that had claims that were "deleted by MAXIMUS." My question is, we contacted Novitas and they supposedly contacted MAXIMUS and got the three claims reinstated. But is there also a possibility that the same thing is happening at the ALJ level, that because we were part of the settlement, our ALJ coding-only claims — not DRG claims, not level of care — are being held at the ALJ level?

Mark Korpela: So there's no crossover into the patient status. They're truly a DRG denial?

Christina Lucas: That's correct.

Mark Korpela: OK.

Maria Ramirez: So, have you sent in that list to the mailbox, because we will need to coordinate with the MAC to make sure that they are identifying those claims as a DRG denial rather than patient status. And then we will be able to reinstate them in the appeals process.

Christina Lucas: So I sent the list of the three that were on the AdQIC site. But you want also a list of all the ALJ coding-only claims that are out there?

Maria Ramirez: So let me make sure that I understand. Your issue is that your claims were removed from the appeals process, and you need to reinstate them in the appeals process?

Christina Lucas: On the MAXIMUS website, they were deleted.

Maria Ramirez: OK.

Christina Lucas: But there's no way to check the ALJ. There's no ALJ appeals website to go to to see. The claims were all pending.

Maria Ramirez: Actually, if you check — if you check OMHA's website, they do have a way for you to check the status of a claim if you enter the ALJ appeal number.

Christina Lucas: Go to the OMHA website?

Maria Ramirez: Yes.

Christina Lucas: OK.

Maria Ramirez: If you still don't see your claims as pending, that means that they were probably temporarily deleted from the system, which means we would need to coordinate with the MAC to make sure that they are reinstated in the process.

Christina Lucas: And we are ...

Maria Ramirez: So if — go ahead and check the OMHA website. If you don't see that, send an email to the CMS [Medicare Appeals mailbox](#) and just say, you know, ALJ on the subject line, and we will make sure that we coordinate with the MAC.

Christina Lucas: Thank you. I have one additional quick question. On our level — on our Round 1 settlements, we did get a check. But in reconciling, we found out that the claims that had originally started as DRG and were turned into level of care, we were only paid the level of care amount and not the original DRG from the first demand letter. Are these going to be put by the MAC onto the second round sheet?

Mark Korpela: It's Mark. The answer is, I'm not sure. We'd have to coordinate with the MAC to look at the specific issue to see if they are going to be added back to Round 2. So you're saying they were added to Round 1, but they're paid — what you're saying is, incorrectly.

Christina Lucas: They were paid incorrectly, and we immediately, upon receiving the settlement and when I was adjusting the individual claims, realized there were these claims, and I immediately let the website know — your [Medicare Appeals Settlement website](#) — know about these claims.

Mark Korpela: OK.

Christina Lucas: But we have not had any finalization of them.

Mark Korpela: OK. Again, just to verify, they were paid at the originally submitted DRG amount or what was determined later as the DRG?

Christina Lucas: What was determined later as the DRG. In other words, when they were originally — the first DRG review result letter, when we got the demand letter for the change of DRG, and we submitted to Novitas on appeal, we then became level of care. We got a second demand letter for the remainder of the DRG. So we sent in two checks. When the settlement agreement came, we were paid on the 68 percent of the second check but never the 68 percent of the first demand letter that we sent back — the first check to reconcile the first demand letter.

Mark Korpela: OK. So, without knowing exactly what the MAC did and seeing the claim, I can't give you the final answer here. We can do it through the mailbox we're talking about. If you want to put in the subject line — if you explain what it is in the subject line. And also, when you submit your Round 2, which you may have already done, when the MAC gets back to you, you're going to have a chance to communicate with them at that point. So there's a couple of different ways we can approach that. One, you could email the box now. But ultimately, we need to work with the MAC.

Christina Lucas: The MAC is aware of this.

Mark Korpela: OK. I'd have to talk to the MAC. And I would suggest you send in the questions to the [mailbox](#), to the general [mailbox](#) again, and we'll address it with them, just to make sure we know who the provider is and what the issue is, and then we can reach out to the MAC.

Christina Lucas: All right. Thank you very much.

Mark Korpela: Thank you.

Christina Lucas: Bye.

**Operator:** Your next question comes from the line of Vicky Walker. Vicky, your line is open. OK, Vicky withdrew her question.

Your next question comes from the line of Lydia Stewart.

Lydia Stewart: My question has been answered, thank you.

**Operator:** Your next question comes from the line of Ken Sailors.

Ken Sailors: My question has been answered, thank you.

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

Andrea Lens: Yes, hello. My question pertains to the dismissal. Will that go to our appeal entity, the folks who are handling our appeals for us, or will they come directly to our hospital?

Maria Ramirez: Usually the dismissal letter goes to whoever was appealing. So whoever requested the appeal will receive the letter.

Andrea Lens: OK.

Maria Ramirez: So ...

Andrea Lens: Could you ...

Maria Ramirez: You need to get a copy — you need to coordinate with whoever...

Andrea Lens: OK, thank you.

Maria Ramirez: Sure.

Andrea Lens: Could you all tell us that OMHA website that — where we could look at those appeals, also? Do you all have that handy?

Maria Ramirez: Actually, if you go to HHS/OMHA or something along those lines ...

Andrea Lens: Um-hum.

Maria Ramirez: I believe that they do provide a link for status update on your appeals.

Andrea Lens: OK.

Maria Ramirez: And you will be able to see it there.

Andrea Lens: OK. OK, I'll give that a try. All right. Thank you very much.

Maria Ramirez: Thank you.

**Operator:** Your next question comes from the line of Lila Ola.

Lila Ola: Hello. We've been receiving some claims or we have a bunch of claims that were previously favorable for our hospitals. And now we're seeing CMS come back and deny them again. And I'm wondering if those are going to be now listed on the settlement?

Maria Ramirez: Can you provide more details? I mean ...

Mark Korpela: When you receive the determination prior to the settlement on those claims?

Lila Ola: Yes. So we received a favorable determination for the hospital, the ones that we appealed. They are level of care. And now CMS has reversed that favorable decision. And so I'm wondering if we continue with the appeal process for those or if we expect them to show up on the settlement now?

Maria Ramirez: Did you already receive a determination on those claims?

Lila Ola: Yes, they were both ...

Maria Ramirez: And were they — and they were paid or not paid?

Lila Ola: I'd have to look and see if they were paid or not. I'm not sure.

Maria Ramirez: So — and when did you submit your settlement agreement and when did you receive the decision?

Lila Ola: It's just recently that we're receiving the reversal of the original decisions.

Maria Ramirez: And when did you ...

Lila Ola: And we sent our settlement for Round 2 — well, we received payment already for Round 1 for all of our hospitals. And Round 2, we've already submit all of our disagreements.

Maria Ramirez: We're going to probably have to look into that and make sure that through this Round 2 we reconcile the claims that were already adjudicated and paid and the ones that will be settled in this Round 2.

Mark Korpela: Yes. What — something I was mentioning earlier, at the end of all this, we're going to do a claim reconciliation to make sure we have all the proper claims in the proper categories and the information is transmitted properly. So this sounds like one that we'll have to get at reconciliation. If there's something specific you want us to see in advance of that, feel free to send it in to the [mailbox](#) and we'll take a look at it.

Lila Ola: OK.

Mark Korpela: And let me add while the line's open, the previous question about the OMHA website, it's [hhs.gov/omha](https://hhs.gov/omha). And you'll be able to get to their website.

**Operator:** Your next question comes from the line of Christina Gray.

Christina Gray: Yes, hello. I heard that the turnaround for the Round 2, the next phase of Round 2, when the MAC sends us back the spreadsheet with the three tabs, will be about a month we're anticipating. What about the provider response to that? Do we have an idea of a timeframe there?

Mark Korpela: Sure, so they'll send an email, but ideally we would request 14 days. I mean, we were hoping the MACs will get some of these out sooner, but we're giving them a month because of the volume. And it could be staggered a little bit, depending on when your Round 2 was submitted. But ideally, a 14-day — calendar day response would be great. But if you have issues with that, please let the MAC know and they can work with you.

Christina Gray: Thank you.

**Operator:** Your next question comes from the line of Lauren Barium. Lauren, your line is open. If you're on mute, please unmute your line and proceed with your question.

Your next question comes from the line of Mary Miklocheck.

Mary Miklocheck: Yes, thank you for taking my question. For the Round 2, the information the MAC is going to send us, will we need to sign another agreement? I know the CMS is going to sign the agreement, but will we need our financial officer to resign again?

Mark Korpela: So, did you already submit a Round 2 request?

Mary Miklocheck: Yes, we did. We did, and we submitted it within the 14 days, and I'm happy you're having this call today. This is really good information. But I just wondered if we should be preparing to get another signature. If CMS accepts what we sent in, will we get another form for our CFO to sign?

Mark Korpela: Sure. When that first documentation came in for Round 2, there were supposed to be two documents with it, one being your signed agreement — a new signed agreement — and then the claims listing. If that was incomplete, our contractor should have reached out to you to let you know that it was incomplete, but I can't guarantee that that's happened for every provider. So, do you know if an agreement ...

Mary Miklocheck: Well, we sent in — Yes, oh yes, absolutely, yes ...

Mark Korpela: OK, so your point?

Mary Miklocheck: ... we did.

Mark Korpela: So then you're fine, and what's going to happen is when the MAC is completed and it goes back and forth with you and it's ready to go, we'll sign here at CMS. So you do not need to sign another one.

Mary Miklocheck: OK. Thank you very much. I just wanted to be sure we shouldn't be ready to sign again.

Mark Korpela: Right, you'll need to — you'll get information from the MAC, which they'd like your, you know, I won't say approval, but agreement ...

Mary Miklocheck: Response.

Mark Korpela: Right.

Mary Miklocheck: Sure.

Mark Korpela: But that's it. Now, you shouldn't need another signature.

Mary Miklocheck: OK, and the MACs, will they be communicating? I'm the contact person at our organization. Well, you've mentioned a few times, if we send them something, they're supposed to acknowledge they've received it and such. Will it be coming to the same contact that you have established with us already?

Mark Korpela: Yes. Most of the time, the contact that is made is with the name that is on the Settlement Agreement when it's submitted because that's where you put your contact information.

Mary Miklocheck: Right.

Mark Korpela: If by any chance — If that's the case, then it should go there.

Mary Miklocheck: OK.

Mark Korpela: I'm throwing this up — I'm adding to that because if the email came from someone else, there is always a chance it could be responded to that person.

Mary: OK, no, we're consistent. The contact person is the one sending the emails. So we just wanted to, hopefully, know that it would be coming back here, so ...

Mark Korpela: That's who'd be communicated with, that person.

Mary Miklocheck: OK. Well, thank you very much.

Mark Korpela: Oh, you're welcome.

**Operator:** Your next question comes from the line of Jackie Powers.

Jackie Powers: Hello, this is Jackie Powers. My question is about the adjustments that you mentioned for interest on Round 1. We did receive a lump sum payment on a recent remittance, but there was no information regarding the specifics to the payment. Is there a way that we could validate that that is, in fact, an adjustment to the claims or an interest adjustment?

Mark Korpela: Yes, we can't do that for you here because all the information is at the MAC. So you'd have to reach out to the MAC, and they can explain to you what's on that remittance advice. Anytime that they – anytime they do the reconciliation we discussed, they should send you an email in advance so you're aware of the amount. I mean, it is possible you didn't get it, but hopefully an email would come when this happens.

Jackie Powers: I haven't received an email, and we've attempted to reach out to the MAC via their standard customer service line, and we're having difficulty finding someone that understands how to interpret the lump sum payment. Is there another avenue that we would follow associated with the settlement process?

Mark Korpela: Yes, any questions for the remit would normally go through that or anyone you work with your claims because they understand the remit. If needed, it can be sent to our general [mailbox](#) here and we can try to route it to them.

Jackie Powers: OK, that may be helpful. We'll make one more attempt ...

Mark Korpela: OK.

Jackie Powers: ... with the MAC. Thank you.

**Operator:** Your next question comes from the line of Stephanie Gibson.

Stephanie Gibson: Our question has already been answered, thank you.

**Operator:** Your next question comes from the line of Nicole Moran.

Nicole Moran: My question's been answered as well. Thank you.

**Operator:** Your next question comes from the line of Kerry McCray. Kerry McCray, your line is open.

Kerry McCray: Hi, can you hear me?

**Operator:** Yes, please proceed with your question.

Kerry McCray: OK, our question was, we had submitted a Round 1 within the timeframe, received information back. We did not have, you know, a third tab to enter any disagreement information. We sent back all eligible claims, and we did send another signature from our CFO. And we had sent that just before Thanksgiving. So the 60 days to hear anything back from our MAC expired sometime in January. We have sent an email to them, and they said they're working on it, they received it. When can we expect to hear a response?

Mark Korpela: I want to make sure I understood the beginning of that. So Round 1 was completed, but you just haven't received payment?

Kerry McCray: No, Round 1 was sent in.

Mark Korpela: OK.

Kerry McCray: So then maybe the question is, are we still in Round 1?

Mark Korpela: Technically, yes. So, there's some — many providers have been paid, and there are still some in Round 1 for various reasons. It could just be documentation, and just various reasons there's still some in process. So, yes, I didn't want you to think that Round 1 is closed and you're not part of that. We can do the status again through an email if you want to send that in to us.

Kerry McCray: OK.

Mark Korpela: We are aware that there are some in process. So, I mean, that's the best information I can give you on the call.

Kerry McCray: OK, thank you.

Mark Korpela: And — OK, go ahead.

**Operator:** Your next question comes from the line of Samantha Karpenko.

Samantha Karpenko: Hello, I have one quick question and one followup. So on the Round 2 agreement that we submitted, did that require a new signature or could we use the same signed agreement that we submitted in Round 1?

Mark Korpela: Round 2 did require a new agreement. It could be the same person, it could be, you know, almost the same as the first, but it is a separate agreement. If you did ...

Samantha Karpenko: OK.

Mark Korpela: If you send an email ...

Samantha Karpenko: So I think I resubmitted the same PDF document of the — of the agreement that I submitted in Round 1. So I'm wondering if I should — I didn't get a request for a different one or anything, but listening to some of the questions a few minutes ago, it made me wonder if I should have sent a new signature.

Mark Korpela: I would recommend sending it again just so it's in there, because it will be tracked and it will replace the other one, and then just note in the email why you're sending it. It'd be better to do it now than find out later and have to come back to get another one.

Samantha Karpenko: OK. And then my second question is, at the end of Round 1 for one of my facilities, I only ended up with ineligible claims on the disagreements list. There were claims that my MAC had added. I did not submit them in the original submission, and my MAC came in and added a long list of claims, and I disagreed that any of those were eligible for various reasons. So I didn't really have a Round 2 submission because I didn't have any appeals that were left unsettled after Round 1. But I'm wondering if I need to have a Round 2 still so that all of those can go on the Ineligible Claims tab — that we agree they're ineligible, or is it — are these just going to be OK?

Mark Korpela: It sounds like, if I'm hearing this correctly, your MAC added claims to your listing saying that they were ineligible, and then you say that they're ineligible, so there's a disagreement ...

Samantha Karpenko: No, they added claims — when they came back with my disagreement list on Round 1, they had added a bunch of claims that I had not included in my initial settlement. They were claims that the — like the expiration — or the submission deadline had expired and we had decided not to continue to the ALJ with those. And so they — I knew that they weren't eligible because they were past the deadline, but they added them to the spreadsheet.

So, I didn't — I knew they shouldn't be settled, and so I didn't have a Round 2 to submit, and I never did submit a Round 2 for that facility. But I'm worried if they're supposed to be on that tab B, Ineligible Claims-Agree.

Mark Korpela: From what I'm hearing, it sounds like it should be because it sounds like, again without knowing all the details, it sounds like the MAC is adding claims they believe should be in the settlement even though you don't think they should be in the settlement. And if we don't go through a Round 2 process, they may continue with a Round 2 process because if they feel there's eligible claims, they would pay them as part of the settlement. Where it sounds like you don't want them in the settlement, and you don't believe they belong there. So it sounds like we need some communication with the MAC to ensure that they're properly included or excluded.

But it's —then ...

Samantha Karpenko: OK.

Mark Korpela: ... I'm also hearing you didn't send in a Round 2. So ...

Samantha Karpenko: I didn't because I didn't feel like I had anything that I was supposed to get any Round 2 lump sum payment on. I feel like — all of my — we agreed on everything I submitted in Round 1. So I didn't have anything I needed to ask for in Round 2.

Mark Korpela: All right.

Samantha Karpenko: It was just some stuff they added.

Mark Korpela: I think I understand what you're saying. It does sound like a Round 2 is needed. These are ones that, even if you don't initiate it, if the MAC is still aware of claims that should be in the settlement, they will be reaching out, or our contractor, Santiva, will. I would recommend that you send an email to the box to explain that so they can take a look to determine if it is something that should go to Round 2. If you choose not to, I believe the MAC is still going to look at that at some point, so you may hear from them. But ...

Samantha Karpenko: OK.

Mark Korpela: ... to close the loop ...

Samantha Karpenko: OK.

Mark Korpela: ... I would recommend sending an email to that [email box](#) to explain what's going on.

Samantha Karpenko: OK, thank you.

Mark Korpela: Thanks.

**Operator:** Your next question comes from the line of Yvette Hayes.

Yvette Hayes: Hi. Under Round 2, your critical steps number 18, where you talk about the payment recruitment reconciliation process, we received after Round 1, just recently, an email from the MAC stating that they had found a duplicate claim and that they would — may be making a demand for repaying the net amount. Well, we took a quick look at it, and it really was not a duplicate. It actually was one where the

DCN number was incorrectly stated because it has — they both have two different dates of service and so forth.

Anyways, the email that I got back from them said that — let's see, I was going to pick it up before I got back on the phone call.

Yvette Hayes: ... that it was past the timely period to make a redetermination. I guess my question is, if we find one where we don't agree with that determination, during the reconciliation process, would it be possible to have that added to Round 2 because, in fact, it wasn't a duplicate, it just didn't have the right DCN number?

Mark Korpela: Yes, that is possible to put in Round 2. I don't know why the MAC would've said it was a duplicate if it wasn't. So ...

Yvette Hayes: Well, because of the way had it listed, you would have thought that they were the same, but they had two different dates of service.

Mark Korpela: OK.

Yvette Hayes: We just had the wrong DCN number listed.

Mark Korpela: So in — now your Round 2 was, I'm sure, or probably already submitted. So you would need to communicate with your MAC. Now, they're going to come back to you when they look at the Round 2. You can talk about it then or as soon as possible, it would be good for you to communicate with them so they know that there's something else that should be added.

Yvette Hayes: Well, I have, and I think what I will do, based on this conversation, is just tell them that I understand it's too late to have any effect on Round 1 and/or to stop the demand letter, but we would like to have that claim added to Round 2.

Mark Korpela: Yes.

Yvette Hayes: Is that the best way you think to go? OK.

Mark Korpela: It is the best. And I understand the concern that a demand letter was sent for something that you may be paid later. I mean, the best would be for you to reach out to the MAC now. I think it would be — depending on the issue, you'd have to talk to the MAC, maybe a corrected payment for Round 1 could be made, but I — without knowing all the details, I can't give you that answer on the call.

Yvette Hayes: OK, but you don't think that it rules out the possibility that it could still be considered during Round 2?

Mark Korpela: No, it does not rule it out. I agree that it could be part of Round 2.

Yvette Hayes: OK, thank you.

Mark Korpela: OK, thanks.

**Operator:** Your next question comes from the line of Amanda Wilkerson.

Amanda Wilkerson: Yes, good afternoon. I wanted to ask the question, where we saved our Round 1 back and then it has the disagreement of claims, there was a narrative note that stated “claim record not found.” What does that mean?

Mark Korpela: Well, it depends on the MAC, I believe. I mean, what it says is —all I’m hearing is that they couldn’t find the claim. I don’t have —we don’t have a specific — I mean, I’m only going off of what I’m hearing. So you’d have to work with the MAC on that to determine what actually is the problem. For whatever reason, they’re not identifying that claim. I’m sorry, I just can’t — I can’t answer that without knowing all the claim detail.

Amanda Wilkerson: OK. On an earlier question, a lady mentioned the RAC had deleted some. So I’m guessing that may have happened to us. And then we also have some that went through RAC that is with Connolly. So we just need to go back to MAC on both of those?

Mark Korpela: Yes, you would still have to work with the MAC on that because they’re ultimately the one that effectuates the denial.

Amanda Wilkerson: OK, because we didn’t really know how to respond, so we put in there where we had sent, you know, certified appeals. So we will follow up with MAC then because there was a — we had a lot of claims with that narrative.

Mark Korpela: OK, that’s interesting. Yes, you would have to follow up with them. If you’re having issues with that, you can email the [general mailbox](#).

Amanda Wilkerson: When you say the general mailbox, which ...

Mark Korpela: The CMS one that I was giving out, the [medicareappealssettlement@cms.hhs.gov](mailto:medicareappealssettlement@cms.hhs.gov). If you’re having any issues with the MAC and you need resolution. Hopefully, you could work with the MAC, that would be the best course. But you can always send a secondary email to that general email box.

Amanda Wilkerson: All right. Thank you very much.

Mark Korpela: Victoria, we're, I believe, approaching the end of the time. Can we — I don't know how many are in the queue but can we limit?

**Operator:** Certainly. Your final question comes from the line of Richard Pierre.

Richard Pierre: Hello Mark.

Mark Korpela: Hello.

Richard Pierre: You had commented earlier that if the hospital disagrees with NGS, CMS is going to make the final decision. Does that mean that we have to close it with ALJ, the fair hearing officer, if we've got that still pending?

Mark Korpela: If you and your MAC, NGS, can't agree on the eligibility of the claim, they're going to bring it here so we can review it. Then the decision — basically, that decision will determine where it's going to go in the process. If it's ineligible, it's going to go back in the appeals process. I guess it depends on what happens. I don't have an exact answer for that.

Richard Pierre: OK.

Mark Korpela: We're only talking about the eligibility of the claims, that if you can't work it out with NGS and agree, then we're going to step in and try to make the determination of what — whether it's eligible or not.

Richard Pierre: But we could continue with the ALJ or fair hearing if necessary.

Mark Korpela: Well, if we determine that it's eligible, if we have proof that it's an eligible claim, it would be paid as part of the settlement. If it's ineligible, it would then — yes, then you would pursue the appeal.

Richard Pierre: OK. All right, thank you.

## Conclusion

Mark Korpela: All right. You're welcome. OK, Victoria, thank you very much. I'll let you do your closing.

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

-END-

