FREQUENTLY ASKED QUESTIONS

Hospital Appeals Settlement for Fee-For-Service Denials Based on Patient Status Reviews for Admissions Prior to October 1, 2013

A. GENERAL QUESTIONS:

1. Why is CMS offering a settlement?

CMS believes that the changes in Final Rule 1599-F,[1] the so called "the 2 midnight rule," (published in August 2013) will reduce ***future*** appeals volume. However, in order to more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS is offering an administrative agreement to any provider willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). CMS encourages providers with inpatient status claims currently in the appeals process to make use of this administrative agreement mechanism to alleviate the administrative burden of current appeals on both the provider and Medicare.

2. What authority does CMS have to do this type of settlement?

CMS is offering this settlement pursuant to the Social Security Act and CMS's regulations regarding claims collection and compromise at 42 C.F.R. 401.601 and 401.613, and regarding compromise of overpayments at 42 C.F.R. 405.376.

3. What is the deadline for a hospital to submit the signed administrative agreement?

Providers should submit the required documents by October 31, 2014. However, providers may request an extension from CMS if they are not able to meet this deadline.

4. Is this settlement indicative of fault on behalf of CMS policy or the provider requesting the settlement?

The parties will make no admission of fault or liability with regard to the administratively-resolved eligible claims. This is an effort to quickly reduce the volume of inpatient claims currently in the appeals process.

5. Who is authorized to sign the administrative agreement on behalf of the provider?

[1] *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status*

The person who executes the administrative agreement represents and warrants that they are fully authorized to sign on behalf of the provider.

6. How long will it take CMS to complete the settlement?

CMS and its contractors will work as expediently as possible to validate the eligible claim spreadsheet submitted. Once the claims are validated, payment will be made within 60 days of a signed agreement from CMS.

7. How are Recovery Auditor contingency fees impacted by this settlement offer?

Recovery Auditor contingency fees are governed by contract requirements and will be handled accordingly.

B. ELIGIBILITY:

1. Which providers are eligible for the settlement?

The following facility types ARE ELIGIBLE to submit a settlement request:

- Acute Care Hospitals, including those paid via Prospective Payment System (PPS), Periodic Interim Payments (PIP), and Maryland waiver; and
- Critical Access Hospitals (paid under both Method I and II)

The following facility types are NOT eligible to submit a settlement request:

- Psychiatric hospitals paid under the Inpatient Psychiatric Facilities (IPF) PPS;
- Inpatient Rehabilitation Facilities (IRFs);
- Long-Term Care Hospitals (LTCHs);
- Cancer hospitals; and
- Children's hospitals.

A full definition of each of these facility types can be found at §1886(d) or §1820(c) of the Social Security Act.

2. Must Hospitals under common ownership or control submit a single Administrative Agreement and Spreadsheet? Consider the following 2 examples:

- **Example One: ABC Hospital Chain comprises five hospitals, and each hospital has its own provider number. Will CMS allow some of those hospitals to participate while the other ones might decide to continue with appeals?**
- **Example Two: XYZ Hospital Chain comprises five hospitals all under a single provider number. Will CMS allow some of those hospitals to participate while the other ones might decide to continue with appeals?**

The settlement process requires EACH PROVIDER NUMBER to submit a separate administrative agreement and spreadsheet. EACH ORGANIZATION WITH A PROVIDER NUMBER must choose to accept the settlement offer (allowing ALL of its eligible appeals to be dismissed), or choose to continue with appeals. Regarding the examples above:

- Example One: Each hospital in the ABC Chain may decide whether to participate or not. If an ABC Hospital chooses to participate, it must include all claims from that provider number on its spreadsheet. If one ABC Hospital participates, that does not mean that all other ABC Hospitals have to. Each ABC Hospital can make its own decision whether to participate or not.
- Example Two: Because XYZ Hospital Chain has a single provider number, the XYZ Chain must decide whether to participate or not. If XYZ Chain chooses to participate, it must include all claims from its provider number on its spreadsheet.

3. Must a hospital settle all eligible appeals?

Yes, for the provider to receive any payment as part of this settlement, the provider must settle all eligible appeals. The provider may not choose to settle some claims and continue to appeal others. See Q&As B1 and B2 for a full definition of the term "provider" in this settlement process.

4. What claims are eligible for settlement?

Claims are eligible to be included in a provider's request if:

- The claim was not for items/services provided to a Medicare Part C enrollee
- The claim was denied due to a patient status audit conducted by a Medicare contractor, on the basis that services may have been reasonable and necessary, but treatment on an inpatient basis was not, and
- The claim has a dates of admission prior to October 1, 2013, and
- As of the date the provider signs and submits their first administrative agreement with the list of eligible claims:

a. the appeal decision was still pending at the MAC, QIC ALJ or DAB; **or**
b. the provider had not yet exhausted their appeal rights at the MAC, QIC, ALJ or DAB levels

5. What if the hospital claim was denied for a reason other than "patient status," such as coding?

Provider inpatient claims denied for reasons ***other than*** inpatient status, when the "services may have been reasonable and necessary but treatment on an inpatient basis was not" are not eligible for this agreement.

C. PROCESS:

1. Who is authorized to be the point of contact on the eligible claims spreadsheet?

Anyone can be listed as the provider's point of contact.

2. Can CMS clarify the Provider Number requested on the spreadsheet?

The 6-digit Provider Number is also known as the CMS Certification Number (CCN), Online Survey Certification and Reporting (OSCAR) or Provider Transaction Access Number (PTAN).

3. Can providers include multiple provider numbers on one spreadsheet?

No, CMS needs to receive one administrative agreement and spreadsheet per provider number. If a chain hospital has multiple provider numbers, separate settlement requests (including administrative agreement and eligible claims spreadsheet) must be submitted for each. The spreadsheet can include multiple National Provider Identifications (NPIs) associated with each provider number.

4. How will the hospital and CMS reconcile discrepancies between the claims lists?

CMS and its contractors will work collaboratively to validate the claims list submitted by the provider. If necessary, CMS and its contractors will engage in discussions with the provider to reconcile discrepancies. CMS will proceed with a fully executed administrative agreement on those claims with which both the provider and CMS agree are subject to settlement while working to reconcile the remaining outstanding claims.

5. Is there a deadline for hospitals to submit their Round 2 settlement request and spreadsheet?

Providers should submit their round two request within 14 days of receipt of an email from CMS containing a list of "disagreement" claims.

6. Will the provider have the opportunity to review the final settlement amount before CMS executes the administrative agreement?

After validation, the MAC will send the eligible claim spreadsheet back to the provider for final review. After review, the provider shall email CMS whether it wants to proceed with settlement for the amount as determined by the MAC, or whether it wants to abandon the settlement process. If the provider chooses to proceed, CMS will sign the administrative agreement and the MAC will proceed with issuing the settlement payment.

7. How will the settlement affect the claim's history?

The claim will remain as denied and no claim-level adjustments will take place. A Medicare Summary notice (MSN) will not be sent to the beneficiary.

D. APPEALS IMPACT:

[RESERVED FOR FUTURE USE]

E. WITHDRAWALS:

1. What if the hospital wishes to withdraw from the settlement process?

At any point prior to a fully executed administrative agreement, the provider may abandon the settlement process. The term "fully executed agreement" means that an administrative agreement has been signed by both the provider and CMS. If a provider and CMS have signed an initial administrative agreement to settle a partial list of agreed upon claims, then the provider may only opt out of the process for those claims that were not captured by that initial administrative agreement.

F. PAYMENT:

1. What is the provider's refund responsibility related to the Beneficiary's co-insurance and deductible?

The providers refund responsibility is as follows:

a. If the Beneficiary co-insurance has been collected at the time the INITIAL administrative agreement is signed by the provider, no refund is required.
b. If the Beneficiary co-insurance has not been collected at the time the INITIAL Administrative Agreement is signed by the provider, the provider must cease collections.
c. If a Beneficiary repayment plan has been executed at the time the INITIAL Administrative Agreement is signed by the provider, the provider may continue to collect the co-insurance in accordance with the repayment plan.

2. What happens to recoupment of overpayments for claims that are in the appeal process (or still within the time frame to request an appeal review) that are part of the settlement request?

As part of the validation process at the MACs, recoupments will be suspended.