FREQUENTLY ASKED QUESTIONS

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

Last Updated: 09/26/14

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?

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

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[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*

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.

8. What happens if we do not accept the 68% reimbursement?

The settlement offer is completely voluntary. Providers are not required to submit a settlement request. Providers who do not submit a settlement request will remain in the normal appeal process.

9. Will these claims be excluded from future audits by any/all auditing entity, e.g., MAC, RAC, QIO, CERT, OIG?

Claims that have already been reviewed are always excluded from future review by a MAC and Recovery Auditor. Because CERT chooses claims randomly, it is possible that a handful of these claims will be selected for CERT review. This settlement does not impact reviews being conducted under the false claims act, so ZPIC or OIG reviews of potentially fraudulent claims will continue.

10. Any settlements in the works for appeals of coding denials?

No.

11. Confirm this is a onetime option.

Yes. This is a one-time settlement offer.

12. Question Removed.

13. What if the appeal involves extrapolation? Would a hospital whose appeal involves an extrapolated calculation of the overpayment related to claims denied due to the decision to admit the patient as an inpatient having been found to be improper be eligible to participate in the administrative agreement settlement?

Being involved in an extrapolation case does not make a claim ineligible for settlement.

14. We have paid out a lot of money to send denials to the ALJ level. How can we recoup on this if we agree to take the settlement?

CMS cannot repay costs associated with an appeal. Nevertheless, this opportunity eliminates any further administrative expense.

15. Why should we take a discount when we are likely to win at the ALJ?

A provider should assess its own risks and rewards offered through this settlement opportunity.

16. How will eligible claims that are the subject of the administrative agreement be characterized in the relevant CMS database (such as the Common Working File) for purposes of determining such statistics? Will they be characterized as paid claims? Denied claims?

Claims included in this settlement will remain denied and the appeals will be dismissed.

17. Is the settlement for both Medicare FFS and Medicare Advantage cases in the appeal process? Will Medicare Advantage Plans be affected or encouraged to offer the same kind of settlement terms?

This settlement is only for eligible Medicare Fee-For-Service (FFS) claims.

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.

6. Can we pick and choose the cases we want to settle? Or is an all or nothing selection?

All claims that meet the criteria must be included in the settlement. Each organization with a 6-digit provider number must list all eligible claims on the spreadsheet they submit with their request for settlement.

7. Will inpatient rehabilitation facilities (IRF) also be considered for this settlement?

No. IRFs are not eligible.

7b. If our acute hospital has an IRF and we have had RAC denials for both acute and rehabilitation number, is the IRF eligible for the settlement offer?

Assuming you have one provider number for your IRF and one provider number for your acute care hospital, the acute care hospital is eligible to submit a settlement request. The IRF is not.

8. What categories of denials are included? Just complex RAC reviews, or also CERT, OIG, MAC pre-pay, RAC pre-pay, etc.?

It doesn't matter who made the denial: MAC, RAC, CERT, OIG or ZPIC.

It doesn't matter if the denial was made on a prepayment or post-payment basis

9. Does it cover only short stay or does it cover minor surgery etc.?

The settlement offer is open to all patient status denials including minor surgery admissions denied because although the surgery was necessary, an inpatient stay was not.

10. Does this pertain to coding denials?

No, this settlement is for patient status denials only.

11. Do claims that were "technically denied" (non-submission of records) meet the criteria for this option?

No, claims that were denied for failure to submit medical records are not eligible for this settlement offer.

12. What must be prior to 9/30/13? The Date of Service? The denial? The appeal? or all three?

To be eligible for settlement, the claim's date of admission must be prior to 10/1/13.

13. Does it matter what step of the appeal process the claim is currently in? Or does the settlement only apply to appeals that are stuck at the ALJ level?

No, a claim is eligible if there is a valid appeal pending at ANY level of appeal so long as all other criteria are met. A claim is also eligible if it is within the timeframe to be appealed to the next level of appeal so long as all other criteria are met.

14. What is the cutoff date for "currently pending appeals" as stated in the administrative agreement?

The important date is the date the provider SUBMITS the initial administrative agreement to the CMS email box (MedicareAppealsSettlement@cms.hhs.gov). CMS will send an acknowledgement email when it receives a settlement request to this mailbox.

EXAMPLE: A provider submits an initial settlement request to CMS on September 15, 2014. All valid appeals pending in the process and all claims still within the timeframe to appeal to the next level as of September 15, 2014 would be eligible for inclusion on the spreadsheet (so long as all other criteria are met).

15. Can denied claims that have not been appealed be included?

Yes, but only if they are within the timeframe to be appealed to the next level of appeal and all other criteria are met.

16. Is the settlement offer restricted to appeals in process or can pending appeals that are being appealed to another level be included? Or can we attach past appeals that have been denied?

A claim is eligible for settlement if there is a valid appeal pending in the appeal process OR within the timeframe to be appealed to the next level as of the date the provider submits its settlement request to CMS (so long as all other criteria are met).

17. How far back, regarding date of service can you appeal?

All claims with dates of admission prior to October 1, 2013 are eligible for settlement, regardless of how far back the date of admission goes, assuming the appeal is pending at any point at any level of appeal (or within the timeframe to appeal to the next level of appeal so long as all other criteria are met).

EXAMPLE: A claim with a date of admission of January 24, 2009 is denied by the RAC, a valid appeal is submitted by the hospital and remains pending at the ALJ as of the date the hospital submits its settlement request to CMS. This claim is eligible for settlement.

18. Are hospital Distinct Part Units excluded (IP Rehab, IP Psych)? Are CAHs with distinct part Psychiatric Unit excluded?

Eligible claims under appeal by the acute care and critical access hospital unit may be submitted for resolution through the administrative agreement. Claim appeals involving other distinct units are not eligible for this resolution.

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.

8. Is the 68% partial payment negotiable?

No.

9. Is the 68% settlement offer calculated per claim or is the 68% applied to the sum of all the claims submitted?

The 68% is calculated per claim and then summed into one or two lump-sum payments.

10. Payment at 68% of what amount? Expected Inpatient DRG or expected APC?

The payment will be 68% of the inpatient net paid/payable amount.
Please see question F4 for a definition of net payable.

11. Do we have to resubmit all the claims or can we just fill out the agreement?

Claims included in a settlement will not be resubmitted by the provider. Nor will they be reprocessed by the MAC. Instead, the MAC will issue one or two lump-sum payments.

12. Does each claim in appeal have to be submitted separately by completing the form and spreadsheet or can they be submitted in groups?

For each provider number, an eligible provider will submit one administrative agreement and one spreadsheet listing all eligible claims.

13. How will payment be made? Will CMS clearly and specifically tell which claims have been paid? How will the payment be handled, i.e. patient level or lump sum?

Payment will be made by the MAC in one or two lump sum payments. Before each lump sum payment, CMS will send the hospital an email containing a pdf file containing a list of all claims involved in that payment.

14. Will there be account level information with the payment in order to verify on an account level once account is settled?

Payment will be made by the MAC in one or two lump sum payments. Before each lump sum payment, CMS will send the hospital an email containing a pdf file containing a list of all claims involved in that payment.

15. Approximately how long does CMS foresee the settlement process taking (exchanging of spreadsheets etc.)?

CMS has 60 days to issue payment from the date each agreement is signed. However, CMS expects that most payments will be issued in much less time.

CMS expects the following maximum timeframes will apply from the date the hospital submits a settlement request until the time of a fully executed agreement:
- Medicare "round one" review: 31 days
- Provider time to make abandon/proceed decision: 14 days
- Medicare signs Initial Administrative Agreement: 3 days (sign date starts payment clock)
- Medicare issues email containing pdf of fully executed Initial Administrative Agreement and list of claims included in initial payment: 3 days.
- Medicare "round two" review: 31 days
- Provider time to decide if discussion period is needed: 14 days
- Medicare signs Secondary Administrative Agreement: 3 days (sign date starts payment clock)
- Medicare issues email containing pdf of fully executed Secondary Administrative Agreement and list of claims included in second payment: 3 days.

16. Are there a minimum or maximum number of claims that will be accepted on the application?

There is no minimum or maximum number of claims that can be included in a settlement request.

17. Do we still have appeal rights if we disagree with your assessment?

After the initial round of validation, the MAC will send an email to the provider containing a list of all validated claims, including pricing information. At this point, the provider has 2 choices:
1. abandon the settlement process or
2. proceed with the settlement process.

Providers that choose to proceed with the settlement process are agreeing to dismissal of their pending appeals and waiver of their appeal rights for claims that are within the timeframe to file an appeal for all eligible claims. Providers who disagree with the CMS list of claims and/or pricing should abandon the process and remain in the normal appeal process.

18. Will CMS provide a list of the pending ALJ appeals a facility has on file?

No. The hospital must initiate the process by sending CMS a list of all eligible claims. The list of eligible claims will then be validated using government records.

19. Will CMS and its contractors validate all claims on a hospital's eligible claims list or only a sample?

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

20. If sampling is used, how many claims will be sampled?

CMS contractors will choose a small convenience sample of claims to validate that the case may be at OMHA or the DAB. If this small sample check finds that the hospital has included accurate information on the spreadsheet, the entire spreadsheet will be shared with the hospital with the associated payment amounts for review and concurrence.

21. Do providers and CMS need to only come to agreement on sampled claims or on all claims?

CMS and the hospital must come to agreement on the payment value of all claims on the list. Sampling is meant to expedite claim appeal validation, and to limit the time taken to make payment to a provider.

22. Will the lump-sum payments only be made on sampled claims or on all claims?

If the hospital elects to proceed, CMS will direct the MAC to issue payment for all claims on the list.

23. Do providers only need to include information about claims where hospital data and CMS data not match on revised (Round Two) spreadsheets?

Correct. Round Two only involves claims in which validation was not completed.

24. If we agree to a settlement, what is the earliest to expect a payout from CMS?

CMS expects the earliest payouts will be made to those hospitals who:

- submit their settlement request in early to mid-September;
- have less than 25 claims on their spreadsheet; and
- have a 100% match rate with CMS during Round One.

CMS expects these payouts will begin in October. All payments are expected to be made within 60 days of the fully executed agreement.

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25. Should the claim spreadsheet be sent securely since it includes PHI?

The spreadsheet is not asking for PHI/PII, only claim numbers. However, providers who wish to submit their spreadsheet with a password protected file may do so.

D. APPEALS IMPACT:

1. If we choose the settlement option, will we need to submit withdrawals for the applicable pending appeals?

If a provider finalizes a settlement agreement with CMS, they agree to have all eligible claims dismissed from the appeal process. The hospital is not required to submit withdrawals for the appeals. The finalized settlement agreement serves as a requests for withdrawal of appeals of all eligible claims. Therefore, the MAC/QIC/ALJ/DAB will dismiss any applicable cases based on the finalized settlement agreement.

2. **If facilities elect to participate, do they forfeit appeal rights for all claims even if they are for issues other than inpatient status or just those eligible per the criteria?**

No. Providers are only agreeing to dismissal of appeals of eligible claims. Eligible claims include those where a patient status denial occurred. The provider retains their full rights to appeal other types of denials.

E. ABANDONING THE SETTLEMENT PROCESS :

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

At any point prior to the first 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.

When the provider receives an initial validation email from the MAC, the provider should email CMS at MedicareAppealsSettlement@cms.hhs.gov communicating whether it wishes to abandon or proceed with settlement. The provider should send that email within 14 days. If the provider chooses to abandon the settlement process, CMS will acknowledge receipt of the abandonment request and will notify all levels of appeal. Appeal cases will restart without any loss of days in the timeline.

If the provider chooses to proceed with the settlement process, CMS will acknowledge receipt of the proceed request, CMS will sign the initial administrative agreement to settle a partial list of agreed upon claims, and the provider may no longer opt out of the process.

2. **If the validation process or the reconciliation process becomes burdensome, can a provider cancel its administrative agreement?**

See question E.1 for a discussion of the abandonment process following initial validation. Because the reconciliation process occurs after the agreement is fully executed and payment has been issued, there is no opportunity for a provider to abandon or opt out at that point.

F. PAYMENT: Note: The term "net paid" refers to claims denied on post-payment review. The term "net payable" refers to claims denied on pre-payment review.

1. Now H.9.

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

3. What happens to recoupment of overpayments for claims that are in the appeal process (or still within the timeframe 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.

4. What is the "Net Paid/Payable amount" per the agreement?

CMS agrees to pay the hospital the total sum listed on Attachment A (the eligible claims list on which the hospital and CMS agree), which represents sixty-eight percent of the net paid/payable amount of each eligible denied inpatient claim. "Net paid/payable amount" means the original inpatient Part A claim net paid/payable amount; it excludes the out-of-pocket obligations that are included in the "gross" or "allowable" amounts.

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance: DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance

5. Is the "net paid amount" synonymous with the "recoupment amount"?

Yes, if the claim has been recouped in full and the term "net payable amount" refers to a claim that was denied on pre-payment review.

6. Are payments at 68% to be made against only the Medicare to-be-paid portion or against the whole allowable payment?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance.

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.

7. Could you give an example of a DRG payment and the net paid/payable amount?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.
- Here is an example:
  - DRG payment amount = $2,000
  - DSH add-on = $200
  - IME add-on = $150
  - Deductible = $600
  - Coinsurance = $100
  - Net Paid/Payment Amount = $2,000 + $200 + $150 - $600 - $100 = $1,650
  - Settlement amount for this claim would be 68% * $1,650 = $1,122

8. The settlement is 68% of the actual cash that Medicare originally paid, correct? Not including any patient responsibility portion?

"Net paid/payable" equals the "bottom line" of the claim, after deductible and co-insurance

- DRG payment plus Add-on Payments (DSH & IME interim payments, etc.), minus deductible and co-insurance.

9. Will any prior payment be recouped and the claim repaid under this agreement, or the difference only settled?

Each claim will be calculated individually, and the payment status will be aggregated in order to determine the lump sum payment. Please see paragraph 4 of the administrative agreement for additional information.

G. INTEREST:

1. Does the settlement agreement include repayment of full interest that has already been recouped from the providers?

Yes, any interest paid by the hospital after the claim was denied will be refunded. In addition, if interest has accrued on claims that has not been paid, the accrued interest will be adjusted to zero. Each claim will be adjusted, and it will result in 1 (or 2) lump sum payments made to the hospital.

2. Will providers receive interest for the claims under appeal?

No, interest will not be paid for the claims under appeal. Settlement payment of 68% of the net paid/payable amount will be "payment in full."

3. If we participate in the settlement, do we get paid any interest owed for post-payment recoupments?

No, interest will not be paid for the claims under appeal. Settlement payment of 68% of the net paid/payable amount will be "payment in full."

4. Will CMS pay interest if the settlement payment is not made timely?

Yes. If payment is not made within 60 days of the agreement being signed by CMS, interest will accrue and be paid from day 61 to the date of payment.

H. COST REPORT:

1. Please discuss whether the claims subject to administrative resolution will count toward a provider's Medicare Part A percentage for GME purposes.
Claims will be remain as denied in CMS systems and will not be included for cost report purposes, including the GME Medicare Part A percentage.

2. How will this (the lump sum payment) be handled during cost report audits?
Lump sum payment will not be included for cost report purposes, and claims will remain denied.

3. Providers may not bill beneficiaries for any unpaid cost-sharing amounts-what about uncollected deductibles/coinsurance due? May the provider claim this as Medicare Bad Debt?

The claims will remain as denied in CMS systems. The hospital may not claim the uncollected deductible/coinsurance from these settled claims as Medicare Bad Debt for cost reporting purposes.

4. Since there is no rebilling involved, how will these settled claims appear in the providers PS&R report?

These claims will remain as denied in CMS systems and will not be included on the PS&R or cost report.

5. Will the inpatient days be reduced?

No, total Inpatient Days will remain unchanged on the cost report.

6. Question Removed

7. If we agree to the settlement, will this affect any other reimbursement or payment such as GME/DSH dollars?

The 68% settlement payment includes an allowance for claim add-on payments. However, the data will not be used for cost reporting purposes.

8. Since the claims will not be reprocessed, will this impact open cost reports, DSH, or medical education?

The 68% settlement payment includes an allowance for claim add-on payments. However, the data will not be used for cost reporting purposes.

9. Will the Medicare Cost Report be impacted by the administrative agreement?

No. The administrative agreement results in 1-2 lump-sum payments made to the provider. Claims and the cost reports will not be adjusted for any reason. This includes reimbursement for Disproportionate Share (DSH) payments, Indirect Medical Education (IME), Graduate Medical Education (GME), and any other payments made on the cost report.

I. REBILLING:

1. If the Part B rebilling payment is more than the 68% payment, would the greater payment be made?

No, this settlement provides for 68% of the net paid amount for each eligible denied inpatient claim.

2. If we choose to rebill claims to part B, does the 12 month from date of service rule still apply?

If you accept the settlement, rebilling is not required or permitted. If you do not accept the settlement and instead elect to pursue your Part A claims through the appeals process and to rebill Part B claims, all rebilling rules, including the timely filing rules, remain in effect. Those rebilling rules are not affected by the availability of this settlement.