MLN Connects™

National Provider Call - Transcript

Centers for Medicare & Medicaid Services
CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Appeals of Patient Status Denials
MLN Connects National Provider Call
Moderator: Diane Maupai
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1 p.m. ET

Contents

Operator: At this time I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now give today's conference call over to you, Diane Maupai. Thank you, you may begin.

Announcements and Introduction

Diane Maupai: Hello everyone and thanks for joining us today. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore. I'll be serving as your moderator today. I'd like to welcome you to this National Provider Call on the hospital appeals settlement. Today's National Provider Call is part of the Medicare Learning Network. During this call, CMS experts will be discussing the settlement CMS has offered to acute care hospitals and critical access hospitals for resolving patient status denials. We'll be discussing the why, who, what, and when of the proposed settlement. Before we get started, I have a few announcements.

You should have received a link to the slide presentation for today's call in previous registration emails. If you haven't already done so, please view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the September 9th call from the list.

So second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available. And last, for this call registrants were given the opportunity to submit questions. We thank everyone who did so, we got many. We have addressed many of those questions during today's presentation and we've also posted Hospital Settlement FAQs on the Inpatient Hospital Reviews web page, and we'll get to that link in a little bit.

At this time let's move to slide 4, and I'll introduce our CMS speakers. Our first is Jerry Walters, who is a Senior Advisor to the Chief Financial Officer, the Office of Financial Management. We also have Melanie Combs-Dyer, who's the Director of the Provider Compliance Group. We also have Amy Cinquegrani, who's a Health Insurance Specialist in the Provider Compliance Group.

Moving to slide 5, Gerry will start us off with background and a high-level overview of the settlement. Melanie will cover eligible providers and eligible claims. Amy will discuss validation, payment, and available resources. We will then open the line for your questions. And with that, I will turn the call over to Jerry.

Presentation

Jerry Walters: Thank you Diane, I appreciate that, and let me say also, welcome everyone to today's National Provider Call. And as Diane has mentioned, today's topic is the CMS hospital appeals settlement offer. So I have two key goals in mind for today's call that I'd like to accomplish. First, we want to provide some background about the settlement offer

and how it will work. Secondly, and perhaps most importantly, is to provide today's participants an opportunity to ask questions, to help you make a choice about participation.

So with this in mind, let's move right to the background. You can follow along in the slides for today's discussion, beginning on page 7. So as everyone is perhaps aware, there is a government wide initiative for seeking and correcting improper payments made. And so as part of that, obviously, the Centers for Medicare & Medicaid Services and the Medicare program does do those type of reviews and performs some work. And with that comes a set of administrative appeal rights that are offered, particularly to health care providers.

So as noted in a Federal Register notice that was released by the Office of Medicare Hearings and Appeals in January of this year, there's been an unprecedented growth in claim appeals, and it exceeds the available adjudication resources to address them. The CMS supports, you know, the Office of Medicare Hearings and Appeals's efforts to bring efficiencies to the appeals process, so we've taken steps to support it. So in the spring of 2013 actually, CMS issued its interim final rule 1455, which provided an opportunity for providers to elect some claims reprocessing and billing for part of these services provided during an inpatient stay. Also in August of last year, CMS issued final rule 1599. We believe that the changes that are in this final rule will not only reduce some improper payments in Part A but also reduce some of the administrative costs of the appeals for both hospitals and the Medicare program.

The Settlement Offer

So moving to slide 8. So what's eligible for this settlement offer? And we're going to touch on this a little bit more again later, and Melanie will do that. But eligible claims are currently pending appeal at any appeal level, you know, from redetermination all the way through to the Departmental Appeals Board at any level, one through four, of inpatient status denials made by Medicare contractors on the basis that:

- A. The services may have been reasonable and necessary, and
- B. Treatment in an inpatient status was not.

So that's the matter of the set of claims that were denied that are under appeal that we were hoping to resolve through the settlement resolution.

So let me move to the slide 9. You know, just to settle these claim appeals CMS had to make a determination and make an offer. Obviously, like in any negotiation, there's a decision about the risk and rewards for both the parties. So CMS has determined that 68 percent of the net payable amount of the denied inpatient claim is a reasonable offer. And I think – encourage everyone to consider this seriously and to take every opportunity that's presented to you.

And so think of net payable amount as like the bottom line of the claim, if that will help anyone. And so the net payment amount is actually what was on the diagnostic related

group plus any add-on payments that might be associated with the DRG, less any of the deductibles or coinsurance. And so it's the bottom line of the claim – 68 percent is the offer for full and final satisfaction that we are offering to providers.

So I know many of you are probably going to have some questions about how this will be treated for cost-reporting purposes. I know there's going to be a lot of questions. And perhaps I think one of the simplest ways to think of it is this – and let me try this – and I know that there will be more questions and we'll do our best to respond to them. But when a hospital receives payment for a previously denied claim as a result of a settlement like we're considering here, the claims, nor the cost reports, are adjusted or revised. So the claims for which payment is going to be made are still considered denied claims for the purposes of cost reporting and reconciliations. So I hope that you will take that into consideration. I am sure that you've experienced perhaps other instances where you've had to consider the values about denied claims.

So let me move on just to mention a couple of other things, and this is very important. Hospitals must agree to dismissal of all of the associated claim appeals. So what that means is, it's all or nothing. You may not choose to settle some and keep others in the appeals platform.

So with that, I am going to move quickly on so we have an opportunity for questions. So I would like to hand the discussion over to Ms. Melanie Combs-Dyer, who will walk us through the process for how to participate and what you should expect. And thank you.

Eligible Providers and Eligible Claims

Melanie Combs-Dyer: Thank you Jerry. I am actually going to start at the very bottom of slide 9. There's a very important footnote here and it talks about what exactly we mean when we refer to the word provider. What we mean is an entity that has a six-digit provider number. Some people call that a CCN or an OSCAR or PTAN number, but it's that six-digit provider number. So when we get to slide 10 and I describe what is an eligible provider, I mean an eligible provider that has that six-digit number. It is a provider that is either an acute care hospital or a critical access hospital and it is not a psych hospital, an inpatient rehab facility, a long-term care hospital, a cancer hospital, or a children's hospital. So again, if you're an acute care hospital and a critical access hospital and you have a six-digit provider number, you are an eligible provider.

Slide 11 then describes what are eligible claims, and there are four requirements, four criteria that must be met for a claim to be considered eligible for settlement.

First, the claim either has to be pending in the appeal process or it has to be within the timeframe to request an appeal review. So for example, if you have received a denial at the QIC level and you're still within the timeframe to appeal to the ALJ, that meets the criteria. Or perhaps you've just received a denial from a recovery auditor and you still are within the timeframe to appeal to first-level appeals, that would meet that criteria.

Number two, the denial has to be based on the appropriateness of the inpatient admission, that is, a patient status review. If it was denied because it was a coding review, that is not eligible. If it was denied because you failed to submit documentation, that is not eligible. It has to be a patient status review.

Number three, the date of admission must be prior to 10/1 of 2013. Again, that was the day that the new rule went into effect. The 2-Midnight Rule went into effect 10/1/2013, so this settlement is only for claims prior to that, where the date of admission is prior to 10/1/2013.

And number four, you have not previously been paid a Part B payment.

How to Initiate a Settlement

Slide 12 talks about how you're going to initiate your settlement. You've sort of listened to all of these questions and answers, you've read the website, you've participated in the calls, you've made your decision – you want to participate. How do you go about doing that? Well, what you need to do is you need to send CMS an email, and we've listed the email box to which you need to send the email at the top of slide 12. Keep in mind that this is a different email box than where you send your frequently asked questions. Questions go to a different mailbox.

This mailbox, MedicareAppealsSettlement@cms.hhs.gov, is not for questions. This is only when you want to actually submit your settlement request. That email needs to contain two important documents: an administrative agreement that has been signed by your facility and a spreadsheet. Now you can find the PDF with that administrative agreement on our website, and the website URL is listed at the bottom of slide 12, it's go.cms.gov/InpatientHospitalReview, and capitalization is important here. The "I," the "H," and the "R" must be capitalized. Again, it's go.cms.gov/InpatientHospitalReview, that's where you can find the blank administrative agreement that you fill in, you sign, and you include that in your email. You can also find an Excel spreadsheet. That is where you will list all of the claims and the appeal numbers that meet the eligibility criteria. Again, it's an all or nothing – you either have to list all your claims on that spreadsheet or say, "No, I am not going to participate in the settlement."

You also have to be agreeing to allow CMS to dismiss your appeals during this validation process. You also need to know that there is a deadline for submitting the settlement request, and that is October 31st of 2014. I am now going to turn it over on slide 13 to Amy, who's going to talk about the validation process once …

Diane Maupai: Give it to me.

Melanie Combs-Dyer: Ah, thank you Diane.

Keypad Polling

Diane Maupai: Oh hi, this is Diane again. So we're going to take a moment and pause to complete keypad polling so that CMS has an accurate count of the number of participants

on the line with us today. Please note there will be a few moments of silence while we tabulate the results. Salema, we're ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Once again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling. I will now turn today's conference call back to Diane Maupai.

Diane Maupai: Thank you Salema, and now I am going to turn the call over to Amy.

Presentation continued

Amy Cinquegrani: Thanks Diane. Again, my name is Amy Cinquegrani. I am with the Provider Compliance Group at CMS. We're going to start back on slide 13. And these next few slides discuss how CMS and our contractors will match our claim information to the information that you've provided in your spreadsheet.

Validation and Payment

Hopefully, we're all going to be in agreement that the information that you submitted is going to match ours and we can move forward with effectuating the settlement. In that case the MAC is going to send an email back to you with the full claims list just for your final review. And really this is mainly so you can have the opportunity to see the final payment amounts, especially how that 68 percent was applied to each of your claims.

And at that point we would ask that you send an email back to CMS just confirming that you wish to proceed with the settlement or that you want to abandon the process. Assuming you want to proceed and you let us know that, CMS will sign the administrative agreement, at which time it becomes a fully executed agreement, and that begins a 60-day clock for the MAC to effectuate the payment. And as mentioned, we do anticipate that most of the payments will be done in less than the 60 days allotted.

That fully executed agreement serves as CMS's instructions to our appeal entities to dismiss the affected appeals. You don't have to request separately that these appeals be dismissed. This is just part of our process from you entering into the settlement. Each of the appeals entities will send a letter confirming the dismissal of the effective claims at their levels. So if your appeals come from multiple levels, expect to get multiple letters.

Moving on to slide 14. This discusses the process if there are some discrepancies between our data and what you've provided. And I did want to point out that the discrepancies also include additional claims that CMS or the contractors are adding to your claims list.

As both Melanie and Jerry pointed out, this is an all-or-nothing deal for eligible claims. So if you have not included some claims on your agreement that are eligible to be included, we will – as part of our validation process – we will include those claims.

So after we're done our matching process, the MAC will send the full list of those agreements and discrepancies back to you for your review. For the claims in which we do agree, we will move forward with the settlement payment for those agreed upon claims, just as we discussed on the last slide. We want to resolve these appeals as quickly as possible, so just as on the previous slide, you'll send back a confirmation email to proceed, we'll instruct our contractors to make payment, and then we'll dismiss those agreed upon claims.

However, for the claims where there are some disagreements, the MAC and the hospital will have some discussions to try to resolve those discrepancies. Once they're all resolved, the MAC will then effectuate a second settlement payment and those claims again will be dismissed and you'll receive a letter to that effect from each of the appeals entities.

Moving on to slide 15, it stresses a little bit more about the settlement payment itself, some of which we have touched on already.

You will receive a single payment for the claims that are involved in the settlement. You will not see a claim-by-claim payment. And, of course, as we mentioned, if there has been a round two validation because of some initial disagreements that we've later resolved, you'll receive a second lump sum payment for those additional claims.

As mentioned, you'll receive your settlement within 60 days of the fully executed agreement, which means that it has been signed by both parties and that clock, again, starts on the date that CMS signs the agreement. At this point you may not collect any additional payment from the beneficiary related to coinsurance and deductibles. If you've already collected coinsurance and deductibles at the time you sign the agreement, you don't have to refund the money. However, if you haven't collected anything at the time you signed the agreement, you can't begin any new collections. And the last caveat to that is that if you have a beneficiary repayment plan in place at the time you sign the agreement, you can continue to collect in accordance with that repayment plan.

Resources

And lastly, on slide 16 we just have a few resources that we want you to be aware of. Our website, as Melanie mentioned, has all the documents that you will need to actually request and enter into that settlement as well as some frequently asked questions that were posted yesterday, which we will be updating regularly. Next is the email address where you actually send your settlement requests, and we have a separate email address that we will take questions at. So please notice that those are two different email addresses for different purposes. So one is for settlements and one is questions. And that concludes the slide presentation so I'll turn it back to Diane.

Question-and-Answer Session

Diane Maupai: Oh, thank you Amy. Our CMS experts will now be taking your questions. Before we begin, I'd like to remind everyone that this call is being recorded and transcribed. Before asking your questions, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one. If you'd like to ask a follow-up question or have more than one question, you can press star 1 to get back into the queue and we'll address additional questions as time permits, that's star 1. All right Salema, we're ready to take our first question.

Operator: To ask a question press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you're asking your question so anything that you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

The first question comes from the line of Kelly Shatto.

Kelly Shatto: Hi, can you hear me?

Diane Maupai: Yes, go ahead.

Kelly Shatto: Hi. Amy, you had mentioned on slide 15 that if you have already collected the deductible or coinsurance amount that you don't have to refund the money. That was followed with another statement that I missed, but you said if you were already in process or you already had a policy to collect, can you clarify that?

Amy Cinquegrani: Sure, I said that if you have a beneficiary repayment plan that's in place at the time you've signed, you can continue to collect in accordance with that repayment plan.

Kelly Shatto: Thank you.

Amy Cinquegrani: You can't start the process of collecting.

Kelly Shatto: Thank you very much.

Amy Cinquegrani: Sure.

Diane Maupai: Thank you Amy.

Operator: Your next question comes from the line of Case Ronan.

Dr. Tom McCarter: Hi, this is Dr. Tom McCarter. On slide 9 you stated that the provider's participation in the settlement agreement would be the final administrative and

legal resolution of claims. Would this agreement also be the final resolution for CMS? Specifically, would claims under this agreement be eligible for later review by ZPIC, OIG, the Department of Justice, or other auditors?

Jerry Walters: Well thank you doctor, that's a very good question. And let me be clear here, this is full and final settlement. There will be no pursuing actions post the settlement. And so I think that there is one important caveat to that, which is of course, CMS cannot release liability that might come with a false claim act or something that the Department of Justice might be pursuing. So with that in mind, it is an administrative release of all the claims.

Diane Maupai: Thank you Jerry. Salema, we're ready for our next question.

Operator: The next question comes from the line of Denise Wilson.

Brian McGraw: Hi this is Brian McGraw calling on behalf of Denise Wilson. I am specifically relating to slide 12, the spreadsheet of the claims and appeal numbers. At respective levels of appeal there may or may not be a reference to the term "appeal number" on the claim or on the decision letter. Could you please validate for which particular levels what you mean by "appeal number" on that particular spreadsheet? I know this is a technical question, but we get different information on a RAC letter than we get on a MAC letter than we get on a QIC letter, and they're actually called different things. Could you please help us understand what you mean by the term "appeal number" at each level.

Melanie Combs-Dyer: Thank you Brian, I am going to ask Maria Ramirez from our appeals group to answer that question. Maria.

Maria Ramirez: Hi Brian, this is Maria. So the spreadsheet actually accommodates different numbers, so you can include the claim number. If you have claims that are pending at the QIC level, you can add that number to the spreadsheet. And if you have numbers for appeals pending at the ALJ level, you can also add those numbers. So it doesn't matter what level you have claims pending at, we will be able to identify those. The spreadsheet accommodates for all the numbers.

Brian McGraw: Thank you.

Melanie Combs-Dyer: And did that answer your question?

Brian McGraw: It did, thank you very much.

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

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

Victoria Holzman: Hi, I have a question about page 12, where you said that the appeals – there will be stay in appeals during the validation process. If during the validation process your claim is eliminated, can we then continue with the appeal?

Melanie Combs-Dyer: Yes, if we temporarily put an appeal on hold while we're moving through the validation process and then we later find out that it is not an eligible claim, you will pick back up in the appeal process right where you left off. You are not losing any days by choosing to participate in this validation process.

Victoria Holzman: Is that something that we need to take action on or will it automatically go back into that process.

Melanie Combs-Dyer: Maria?

Maria Ramirez: Yes, you will automatically go into the process.

Victoria Holzman: OK, thank you so much.

Maria Ramirez: Sure.

Operator: Your next question comes from the line of Patricia Kasmarek.

Diane Maupai: Patricia, do you have a question for us?

Patricia Kasmarek: Yes, can you hear us?

Diane Maupai: Yes, now we can.

Patricia Kasmarek: OK, thank you. So our questions had to do with page 15 and the balance after the settlement. So you said we couldn't initiate collection against the patient. What if the patient had a secondary insurance, can we bill the secondary payer?

Melanie Combs-Dyer: This is Melanie, and we're not going to be taking any questions about secondary payers today. We did get a number of questions into our mailbox and we want to make sure that we can work through that fully. We'll make sure that on our next call we add that to our agenda, and if we get an answer before then, we'll post it to our FAQs on our website.

Patricia Kasmarek: OK, so this is on Medicare, it's a secondary payer that I am referring to, but actually a Medicare supplemental payer.

Melanie Combs-Dyer: Thank you, same answer. We will get back to you.

Patricia Kasmarek: OK, thank you.

Operator: Your next question comes from the line of Jessica Gelatt.

Jessica Gelatt: Hi, once the decision has been unfavorable from the ALJ, instead of moving it forward to the Medicare Board of Appeals – is this something that it would be eligible for those appeals as well?

Melanie Combs-Dyer: So Jessica, this is Melanie, and I think your question is, if you have received a denial from the ALJ and you are still within the timeframe to appeal to the next level that I call the DAB, the Departmental Appeals Board, yes, that claim would be eligible. Now if you have waited so long after you get the denial from the ALJ that the timeframe to appeal to the next level has expired, then that claim would not be eligible for settlement.

Jessica Gelatt: OK, great.

Melanie Combs-Dyer: Did that answer your question?

Jessica Gelatt: Yes, thank you very much.

Operator: Your next question comes from the line of Chris Davis.

Chris Davis: Hi, our first question concerns the type of denials that were eligible to present in this settlement. We just wanted to make sure that we were clear on the denials for medical necessity – are those – are you referring to the same group? Or let's say, you know, the review is for medical necessity it's denied, and then they said, for instance, they approved the procedure – let's say it's a total joint – they approved the procedure, but they say that it should not have been inpatient.

Melanie Combs-Dyer: Yes, that would be eligible for this settlement. If at any point in the original denial or anywhere along the appeal process you are denied payment because you should have billed outpatient and instead you billed inpatient, those are things that we call patient status reviews. That claim would be eligible for inclusion here. If you, however, received a denial because the surgery was not medically necessary – that the patient didn't need to have the surgery at all, not inpatient, not outpatient – they didn't need to have it at all, that would not be eligible for this settlement. Same with coding reviews or other types of denials – the duplicate, no documentation, those kinds of things – those would not be eligible. But in the case that you described, where it was denied because it was billed in the wrong setting, yes, that would be eligible.

Chris Davis: OK, so one where, for instance, we failed to provide all the conservative treatment prior to surgery, that would not be considered?

Melanie Combs-Dyer: I believe that would not be considered, that's correct. If you've – if the policy says in order to be covered by Medicare the physician must deliver conservative therapy to the patient before the surgery and this patient did not receive the conservative therapy or the physician documents why the conservative therapy was not appropriate for that patient, it doesn't matter if you did that surgery inpatient or outpatient, that patient does not meet the criteria. That is a medical necessity denial, that

is not a patient status denial, and that particular claim would not be included in this settlement.

Chris Davis: OK, thank you.

Operator: Your next question comes from the line of Lynn Born.

Jen McCavana: Hi, this is Jen McCavana with Lynn Born. I have a question about the speaker that spoke to page 11.

Melanie Combs-Dyer: That's me, go ahead.

Jen McCavana: OK. The slide says, "Not previously withdrawn or billed for Part B payment," but you specifically said if Part B payment hasn't been paid. I am going to put you back on speaker now. So there's a big difference between billed for Part B and paid by Part B.

Melanie Combs-Dyer: So that gets to a question about Part B rebilling, and we have received a number of questions about that. I think I'll ask you to hold that question until our next call. We want to make sure that we're providing you with a full answer, and we're busy gathering information about that particular issue. So let us continue to gather our information and we will put out an FAQ and we will discuss that in future calls.

Diane Maupai: Thank you Melanie.

Jen McCavana: Thank you.

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

Ken Shaw: Hi, this is Ken Shaw from Wheaton Franciscan. I am wondering when you – all these claims are removed that – are they removed from cost report purposes like from the PS&R, so those charges and total days that relate to a particular patient, they'll all disappear from the PS&R?

Melanie Combs-Dyer: This is Melanie, I am going to ask Mark Korpela, our Acting Deputy Director of our Financial Services Group, to answer the question about the cost report.

Mark Korpela: Yes, thanks Melanie. The basic answer is, these claims are treated as denied still in the CMS systems so they will not make their way to the PS&R nor the cost report.

Ken Shaw: So in other words if you were getting GME payments, you're going to lose all those Medicare dates, they're all going to disappear.

Mark Korpela: The days from the PS&R that would have been carried into the cost report, correct, are not carried into the cost report.

Ken Shaw: Right.

Mark Korpela: You are correct.

Ken Shaw: OK. So people should take that into consideration. You are going to get 68 percent, but then you're going – you're going to lose some on a GME payment and if you're at an organ transplant facility, you're going to lose money there, too, because you're going to lose Medicare days. They're not going to show up on the PS&R anymore.

Diane Maupai: Salema, we're ready for our next question.

Operator: Your next question comes from the line of Christena Williams.

Diane Maupai: Christena, we can't hear you.

Operator: Christena, your line is open.

Diane Maupai: OK, let's go on to the next question.

Operator: Yes, the next question comes from the line of Linda Hansen.

Linda Hansen: Linda Hansen from Munson Medical Center. My question is about –we have a number of cases at the ALJ level that are inpatient-only procedures according to CMS – according to CMS, and we are still getting denials on them, how should we proceed with those?

Melanie Combs-Dyer: Things that are denied because they are on the inpatient – let's see are those outpatient claims that you're receiving the denials for?

Linda Hansen: We billed them as inpatient claims that are being denied saying that they're more appropriate at an outpatient level of care, but they are on the CMS inpatient-only list.

Melanie Combs-Dyer: Yes, that would be considered a patient status denial, a patient status review – those would be eligible for the settlement.

Linda Hansen: But they're inpatient only, so we don't, we're – that's what we're struggling with as they are on the inpatient-only list.

Melanie Combs-Dyer: They are still eligible for this settlement.

Diane Maupai: Thank you Melanie. Salema, we're ready for our next question.

Operator: Your next question comes from the line of Jeff Silverstein.

Jeff Silverstein: Yes, hi. I am calling to ask if the denials that are eligible for settlement also include the MAC prepaid denials that have been appealed to the ALJ level.

Melanie Combs-Dyer: This is Melanie, and yes, it doesn't matter if it's MAC prepay or post pay, RAC prepay or post pay, ZPIC prepay or post pay – any contractor who is performing a patient status review and meets – you meet all the other criteria that's on slide 11, it would be eligible for inclusion in the settlement.

Jeff Silverstein: Very good, thank you.

Melanie Combs-Dyer: You're welcome.

Operator: The next question comes from the line of Linda Lattner.

Linda Lattner: I am sorry, can you hear me.

Diane Maupai: Yes, go ahead Linda.

Linda Lattner: Thank you very much. I wanted to ask if we decided to participate in this settlement or not, either way, will we still be paid the interest that was noted in the RAC statement of work?

Mark Korpela: So this is Mark Korpela again. Let me categorize the interest into three categories, and hopefully that will cover – that will cover your question and possibly some others.

Paragraph three of the agreement notes that the payment represents payment in full by Medicare, no further interest or payments on disputed claims covered by this agreement shall be made by Medicare, except that if CMS fails to make payment within the allotted 60 days, CMS will pay interest.

Will there be interest paid if – on the claim, which I believe is what you're asking, the answer would be no. This just would be a settlement, which would constitute payment in full. So on the claim itself there would be no interest paid. However, if the hospital were to have repaid the interest – if interest had accrued during that time and the provider – the hospital had repaid that, that would be refunded. In addition to that, if interest has accrued and the hospital has not paid it yet, that would be adjusted to zero.

And then the last part of that would be if CMS does not pay within 60 days of the agreement, which is the effectuation, meaning CMS's signature, then we would start to accrue interest and pay interest starting on day 61. So I just gave you three different categories for –because we've had numerous interest questions, I believe yours fell into the first category I explained.

Operator: The next question comes from the line of Cathleen Mathey.

Cathleen Mathey: Yes, can you hear me.

Diane Maupai: Yes.

Cathleen Mathey: The question is, when you're talking about the 60 days from the date of the agreement and the initial settlement requests are due October 31st, 2014, and then after that there's a time period where the claims maybe adjusted, so my concern is that this adjustment period, how long do you anticipate that could drag on? Because the 60 days starts once the agreement is final, after all of the adjustments have been made, is that correct?

Melanie Combs-Dyer: You are correct that the 60 days is from the point at which both the hospital and CMS have signed the agreement. And if in the case that you're describing, where there is a disagreement between what you've put on your list and what we think belongs on your list or the information that is listed for each claim. There could need to be some backing and forthing between you and the CMS or our contractors. And your question is, how long will that backing and forthing take? And we really don't – we can't give you a set answer there, it really depends.

I believe that those hospitals who submit a spreadsheet that has three claims on it will go much faster than a hospital that submits a spreadsheet that has 500 claims on the list. And so I think we're just going to have to treat each one individually. We're going to go as quickly as we can. The object of the game here is to try to resolve as many of these as quickly as possible, but I really can't tell you for sure how long it's going to take. Generally speaking, we anticipate that the Medicare contractor can get back to you within 30 days and that you then will have 14 days to get back to us. So we think it will go fairly quickly, but we just can't promise that we're going to be able to get everything resolved in sort of one, you know, one pass at the MAC and one pass at the hospital.

Cathleen Mathey: During that timeframe with the back and forth, which we know from previous appeals process could drag on, these appeals have been – have been stagnated, they're no longer eligible to be considered. So from the point that you sign that agreement on October 31st until there's an agreement, they'll be no money transactions taking place.

Melanie Combs-Dyer: If you, if you…

Cathleen Mathey: I think I understand now.

Melanie Combs-Dyer: Yes, if you choose to submit a settlement request, you are agreeing to stay your appeals to sort of put them on hold while we go through this process. Now if you get to the point where you receive back the list from us and we show you the pricing information, the ones that we agree with, the ones that we disagree with – you have a decision at that point whether you want to proceed or you want to abandon the

process. If you choose to abandon, you're out of the settlement process and your appeals pick up right where you left off. You –automatically, you don't have to re-file anything. You're not starting back at the front of the line; you're picking back up right where you left off. You're not losing any days in the appeal process.

Cathleen Mathey: So after you submit you can abandon it if you don't agree with CMS's redetermination?

Melanie Combs-Dyer: If you tell us that you want to proceed with the settlement, then we will sign the agreement and from that point forward you are agreeing to have all of those appeals dismissed. Any – any other follow-up?

Cathleen Mathey: Oh I am fine, thank you.

Melanie Combs-Dyer: OK. Salema, we're ready for our next question.

Operator: Your next question comes from the line of Teresa Sweatman.

Margie McGee: Hello, this is Margie McGee calling on behalf of Theresa Sweatman, and I just want clarification, during that validation period that for those claims that were prior to October 1, 2013, that were indeed settled up to through the second or ALJ level with full payment, that you won't consider that we didn't report all of the appeals because those appeals were in fact settled with our 100 percent reimbursement of the DRG. Hopefully you don't mean that those we have to list even –although they have already been settled, an agreement was made that we were due the full DRG payment.

Melanie Combs-Dyer: Margie, this is Melanie, and I think I understand your question and I would point you to slide 1, the first criteria. The claim is still pending appeal. In the case that you described the claim is no longer pending appeal. The ALJ has ruled, they ruled in your favor, and so that claim would not be eligible for settlement. You've already gotten your money for that one.

Margie McGee: OK.

Melanie Combs-Dyer: Does that answer your question Margie?

Margie McGee: Yes, it does.

Melanie Combs-Dyer: OK, thank you very much.

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

Mary Myslajek: Yes, I am asking a question again about payments and days. The initial statement was we would be paid 68 percent of the original payment, I believe. But I am understanding since you don't want to count the days, am I correct in understanding you would not include our IME payments for those days? We're a teaching hospital. That

would – we would lose that, it would not be paid at 68 percent, it would be a total loss. And whatever other clarification you can give as to which add-ons are being included in this 68 percent and which payment add-ons are not included. Thank you.

Mark Korpela: So this is Mark Korpela again. I believe Jerry spoke on slide 9, where we talked about the payment amount. Again, the payment amount is the – basically the bottom line of the claim, which would be the DRG plus add-ons, less deductibles and coinsurance. So the example you gave was IME - indirect medical education. If you received an add-on on the claims, that would be included in the bottom line. So you would be – the 68 percent would be calculated based on that. So if there was an add-on for IME and also for disproportionate share and anything else, that would be included in the 68 percent.

Mary Myslajek: Thank you.

Mark Korpela: You're welcome.

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

Judy Bordelon: Can you hear me?

Diane Maupai: Yes Judy, go ahead.

Judy Bordelon: OK, my question you already answered part of it, about determining if the RAC and MAC because we have several out there that are in that process. But does the claim or something we get from the reviewer tell us that it's a patient's status review? How do we validate that?

Melanie Combs-Dyer: Yes, we believe that both the documentation request letter and your denial letter – your review results letter, your demand letter, would tell you that it was denied because the appropriateness of the inpatient setting was not correct.

Judy Bordelon: OK, that's mainly what I am looking at, right, looking for?

Melanie Combs-Dyer: Yes.

Judy Bordelon: OK, that's what I needed to know, thank you.

Diane Maupai: Thank you Melanie.

Operator: The next question comes from the line of LaShunda Smith.

LaShunda Smith: Hello this is LaShunda Smith with Baptist Health. I was asking this question, are we allowed to appeal up unto the day that the decision is made if we're going to be in the settlement or not?

Melanie Combs-Dyer: The question is, can you continue in the appeal process until the time that you enter the settlement process, and the answer is, yes, you can continue business as usual as you are evaluating all of this information and trying to make your decision. But once you submit your signed settlement agreement to CMS, that's the point at which you should assume that everything is stopping. Because it is that submission to CMS date that is important. How things stand on that date is what goes – either gets included on the spreadsheet or gets removed from the spreadsheet. So whatever the status of the claim is on the day you submit to CMS, that's what counts.

LaShunda Smith: All right, thank you very much.

Operator: Your next question comes from the line of Heather Mangeot.

Heather Mangeot: So yes, are there any special considerations for providers that are on PIPs.

Melanie Combs-Dyer: Mark?

Mark Korpela: It's Mark Korpela again. So for PIP providers, the 68 percent would be based on the bottom line of the claim. Even though you're not reimbursed on that claim because you're a PIP provider, you would still receive 68 percent of the bottom line of that claim.

Heather Mangeot: And is there going to be a cash transaction or how – how does that work?

Mark Korpela: Yes, assuming I understand by cash transaction, the 68 percent would be on the bottom line of that claim, it wouldn't be part of the PIP calculation, which you may be referring to. So yes, again if I am understanding properly, the answer would be yes, it would be cash because it's 68 percent of the bottom line of the claim.

Heather Mangeot: OK, and so it would be basically a check in addition to the normal PIP payment?

Mark Korpela: Yes, and again with PIP because the claims do not flow to the PS&R, it would not be included. It would be treated as denied in the CMS systems. So the payment would actually be made on the claim in this case as part of that lump sum payment.

Heather Mangeot: OK great, thank you.

Mark Korpela: You're welcome.

Operator: Your next question comes from the line of Pam Kloeppel.

Diane Maupai: Pam, we can't hear you.

Pam Kloeppel: The question has been answered.
Diane Maupai: Thank you Pam.

Pam Corporal: Thank you.

Operator: The next question comes from the line of Carol Yarbrough.

Carol Yarbrough: Hi there, my question is about the appeal clock stop and start time. So we submit the signed agreements and then appeal clock stops. I guess that means that we're agreeing. But I am wondering when the appeal clock really stops – when we submit the spreadsheet and everything's put on hold or after we put that signed agreement in?

Melanie Combs-Dyer: So the – the important date is the date that you are submitting to CMS. And when you submit that email to CMS that contains your signed administrative agreement and your spreadsheet, you will receive back from CMS an immediate confirmation, just a confirmation of receipt. And that's an important email because that date shows the day that you submitted it to us, the day that we received it.

Carol Yarbrough: OK.

Melanie Combs-Dyer: And as soon as we can communicate that information on to all the levels of appeal, everything is going to fall into place. But we do recognize that it's not going to be immediate and so there could be some sort of backing and forthing as we are adding things to the list or taking things off of the list. But it is how did the appeals stand – how did that claim stand on the day that you submitted to CMS – that's going to drive whether it's included in the settlement or excluded from the settlement.

Carol Yarbrough: OK, great, and then the follow-up question is, if we do not agree to the settlement and wish to proceed with the appeal process for the 100 or so claims, do we deduct that 30 days in the interim from the appeals? Say I've got an appeal due on, say December 2nd, would I add 30 days to that December 2 nd, then it would be due then on January 2nd, or within the same appeal timeframe?

Melanie Combs-Dyer: Are you talking about a claim that is already in the appeal process and you have submitted a settlement agreement and the appeal has been stayed, is that the situation you're describing?

Carol Yarbrough: Yes, and we choose not to accept the settlement when we get the figures back.

Melanie Combs-Dyer: OK, so then you if you send us an abandonment request and everything picks back up and the question to Maria is, if she – let's just say that process took 35 days for – until we receive that abandonment request, does she get the 35 days back?

Maria Ramirez: Does she – it's for adjudication timeframe?
Carol Yarbrough: Yes.

Maria Ramirez: I guess it depends on what level you are at, but I believe that you would. So you would pick up exactly where you left off. So if you were on day 30, then you would start on day 30.

Carol Yarbrough: OK great, thank you.

Operator: Your next question comes from the line of Debra Schultz.

Debra Schultz: Hi, on page 10 of the slides, it lists the facilities that are not eligible for this program. And I am wondering why they were excluded and if there's any plan for a settlement type of agreement in the future for these?

Jerry Walters: Hi, this is Jerry. Let me try to answer your question. When we look at these claims, and again when we're talking about the eligible claims and the appropriateness of the stay, it's the determination that a Medicare contractor has made. We believe the majority – the preponderance I should say – of these denials were for, you know, acute care hospitals and critical access hospitals, and so we've chosen that group to be the ones that we wanted to enter into these agreements. Recognizing that there are other areas, you know, for – psych hospitals, IRFs, or whomever, but right now CMS does not have any plans to enter into any agreements with those provider organizations.

Debra Schultz: Thank you.

Diane Maupai: Salema, we're ready for our next question.

Operator: Your next question comes from the line of Linda Connor.

Linda Connor: This is Linda Connor from Halifax Regional Hospital. My question is regarding like the – I guess the single payment. Is it going to be on the regular remit in a POB segment or exactly how is that payment coming forward?

Mark Korpela: This is Mark Korpela again. It will be on the remit. Unfortunately, I can't tell you exactly what line at this point. Maybe at the next call we'll be able to clarify that for you.

Linda Connor: OK, thank you.

Operator: Your next question comes from the line of Jeannine Engel.

Jeannine Engel: Hi, this is Jeannine Engel, thank you. So I've got to go back to the inpatient-only question that occurred about 10 or 15 questions ago. So I think the question the caller was asking was whether there was some other mechanism to go through for these inpatient-only procedures that have been denied for status. Since

inpatient-only procedures can only be billed as inpatient, it doesn't really seem fair that they would only get 68 cents on the dollar for these.

Melanie Combs-Dyer: If there are providers who believe that the 68 percent is not a good deal for them, they should not enter into the settlement agreement and they should continue to pursue the appeals process. Only if you think that 68 percent and the speedy time – the rapid payment, makes sense for you should you enter into the settlement agreement. Jeannine, does that answer your question, is that responsive?

Jeannine Engel: Well it's responsive. I guess it's just for inpatient-only procedures in essence assuming they're at the ALJ level. The RAC, the MAC, and the QICs have all made an error in saying they should have been billed as outpatient.

Jerry Walters: Well this is Jerry, and also, one, I don't know that we're disputing the decisions that were made by Medicare contractors. I think CMS stands behind those. What we have offered is a reasonable value that we believe if you consider net present value, considering the delay that there may be in the entire appeals pipeline all the way to the appeals board itself, now is the time – 68 percent. Consider the net present value. It is a very good solution, and I really encourage you to consider that.

Jeannine Engel: OK, thank you.

Operator: Your next question comes from the line of Russ Gardner.

Diane Maupai: Russ?

Operator: Mr. Gardner, your line is open.

Diane Maupai: Please move on to the next caller.

Operator: The next question comes from the phone line of Kristine Newcomb.

Kristine Newcomb: Hi, this is Kristi Newcomb, calling on behalf of Deaconess Hospital. My question was in regards to appeals that we may have received a determination in the recent weeks around this settlement offer. For instance, an ALJ case that we only have 60 days to file to the DAB. What would the recommendation be for those cases that might expire or not be eligible for appeal on October 31st?

Melanie Combs-Dyer: This is Melanie, and again the important thing to remember is that it's the date that you submit your request to us. And so, looking at the very top of slide 11, if the claim is pending in the appeal process or in the situation you described, within the timeframe to request an appeal to the next level on the day you submit the settlement request to us, that claim is included in the settlement.

Kristine Newcomb: Thank you.

Operator: The next question comes from the line of Cynthia Bass.

Cynthia Bass: Hi this is Cynthia Bass. I was wondering, we have some ALJ hearings scheduled between now and October 31st. If we get our claim in before October 31st and before the ALJ hearing, does that put that claim in a stay appeal status, or do we need to proceed with our scheduled ALJ hearing and not include that in our claim?

Melanie Combs-Dyer: It depends on if you are able to submit your request to CMS and receive that confirmation email back from us before the hearing is held, before the decision is made by the, by whatever appellant level you're talking about, and/or you're still within a timeframe to request an appeal at the next level, then that particular claim would be eligible for settlement. So in the case that you're talking about, assuming that you send us the settlement request before you get a decision from the ALJ, or even after you get the decision from the ALJ but it's – it's appealable to the next level, still within the timeframe to appeal to the DAB, that claim could – would be – would meet the eligibility requirements for the settlement.

Jerry Walters: So Melanie, this is Jerry. If I may add to that, I have had conversations with Judge Griswold at the Office of Medicare Hearings and Appeals as well as Judge Sussan at the Departmental Appeals Board. I think in your case perhaps the solution may be – contact the appeals tribunal itself and ask them if you – and indicate to them whether you want to proceed with the hearing or whether you would prefer that you stay until you make a decision about inclusion in this settlement offer.

Melanie Combs-Dyer: Does that answer your question?

Cynthia Bass: Yes, thank you.

Operator: The next question comes from the line of Rita Bunn.

Rita Bunn: Hi, my question pertains to slide number 15, and where it states that providers shall not seek additional payment for Medicare beneficiary or collect any deductible or coinsurance amount. If we have not collected the coinsurance, the deductible amount, but we receive a settlement for these accounts, will we still be allowed to report these amounts on our Medicare log for cost reporting purposes?

Mark Korpela: Mark Korpela again. The answer was no. The answer is no, they would not be allowable as Medicare bad debts.

Melanie Combs-Dyer: Rita, did that answer your question?

Rita Bunn: Yes.

Diane Maupai: Salema, we have time for one final question.

Operator: So our final question will come from the line of Jennifer DeBord.

Jennifer DeBord: Hi, this is Jennifer, and I had a question on the spreadsheet actually, Column E, with appeals currently pending with or most recently reviewed at which level. My claim would have been most recently reviewed at QIC and denied, so I've submitted for ALJ. So I am assuming you would want ALJ level in that column E?

Maria Ramirez: Hi, this is Maria Ramirez, and the answer is yes, that is the last adjudicator or where the claim is pending.

Jennifer DeBord: And then column F says the latest pending or adjudicated appeal number. What if the ALJ has not provided me with some sort of recognition that they've received my appeal, because sometimes it could take up to 6 months to get that confirmation?

Maria Ramirez: In that case, then you provide just the information that you have available, which would be the QIC appeal number.

Jennifer DeBord: OK, thank you very much.

Melanie Combs-Dyer: Sure.

Additional Information

Diane Maupai: This is Diane. Unfortunately, that's all the time we have for questions today. On slide 16 you'll find the links for more resources, including those FAQs we mentioned, as well as an email address for submitting any further questions. I also want to call your attention to slide 18, which has – which spells out in full the acronyms used in the slide deck.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We'll release an announcement in the MLN Connects Provider eNews when these are available. On slide 19 of the presentation you'll find information and a URL to evaluate your experience with today's call. These evaluations are anonymous, confidential, and voluntary. We hope you'll take a few minutes to evaluate you MLN Connects Call experience. Again, my name is Diane Maupai. I'd like to thank Jerry, Melanie, and Amy for presenting today. And thank you for participating in today's MLN Connects Call. Have a great day everyone.

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

This document has been edited for spelling and punctuation errors.

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