CMS Offers Settlement to Acute Care Hospitals and CAHs to Resolve Appeals of Patient Status Denials

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In an effort to reduce the volume of inpatient status claims currently pending in the appeals process, the Centers for Medicare & Medicaid Services (CMS) is offering settlement via an Administrative Agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment—68% of the net allowable amount. CMS is encouraging hospitals 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 hospital and Medicare system.”

A copy of the Administrative Agreement and other relevant documents can be found here. Importantly, CMS requires hospitals wishing to engage in this settlement process to submit their settlement requests by October 31, 2014.

1. What types of facilities are eligible to submit a settlement request?
   - Acute Care Hospitals
   - Critical Access Hospitals

2. What types of facilities are not eligible to submit a settlement request?
   - Psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System
   - Inpatient Rehabilitation Facilities (IRFs)
   - Long-Term Care Hospitals (LTCHs)
   - Cancer hospitals
   - Children's hospitals

3. What claims qualify for payment under the Administrative Agreement?

   This Administrative Agreement applies to all “eligible claims” from eligible providers. “Eligible claims” are defined as currently pending appeals of inpatient-status claim denials by Medicare contractors on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, with dates of admissions prior to October 1, 2013, and where the patient was not a Part C enrollee. The hospital may not choose to settle some claims and continue to appeal others; rather, if the hospital decides to participate in the settlement process it must settle all pending appeals. Also, certain hospitals may be excluded from this settlement opportunity based on pending False Claims Act litigation or investigations.

4. What is the process for making a settlement request?

   Eligible facilities have until October 31, 2014 to request an Administrative Agreement unless a request for extension is requested by the facility and ultimately granted by CMS. The request for an Administrative Agreement will then lead to a three-step validation process:

Round 1: Initially, the hospital will submit its proposed spreadsheet of eligible claims/appeals for CMS review with a signed Administrative Agreement. CMS will validate the information and notify the hospital if there are any discrepancies from the contractor eligible claims list. Proceedings on all eligible pending appeals will be stayed. If no discrepancies are identified, then the Administrative Agreement will be countersigned by CMS and payment will be provided—the impacted appeals will be dismissed. If discrepancies are identified, the subset of agreed upon claims will be made the subject of an initial Administrative Agreement signed by both parties, payment will be provided, and the impacted appeals will be dismissed. The subset of claims in which there is disagreement regarding eligibility will continue on to the second round of review.

Round 2: In the second round of review the hospital will review the discrepancies from their first round validation process and resubmit a revised spreadsheet and Administrative Agreement for CMS validation within two weeks of receipt. The parties will continue to conduct these discussions until both parties are in agreement.

Round 3: If the Administrative Law Judge (ALJ) or Departmental Appeals Board (DAB) later identify errors in the agreed upon settlements, they will request that CMS: (i) take back monies for claims that were ineligible for settlement that were inadvertently included; or (ii) pay providers for claims pending appeal that were not part of the agreement.

5. **What immediate actions should eligible providers take?**

Eligible providers should consult with counsel and begin an immediate assessment of their pending appeals with respect to patient status denials. The terms of the Administrative Agreement pose additional questions that hospitals must carefully consider before proceeding. There are pros/cons to participating in this settlement process, and it is extremely important for eligible providers to undergo a comprehensive analysis prior to making a decision and negotiating settlement of Medicare appeals.
Legal Insight

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