Dear Hospital Administrator:

Effective August 29, 2014, the Centers for Medicare & Medicaid Services (CMS) is providing a process for resolving denied claims involving inappropriate patient status determinations that are either under appeal or within their administrative timeframe to request an appeal review. CMS is proposing to make a partial payment (68 percent of the net payable amount of the denied inpatient claim) in exchange for hospitals agreeing to the dismissal of any associated appeals and accept the settlement as final administrative and legal resolution of the eligible claims.

A. Background

1. In the case of claims denied during postpayment review, CMS will make payment of 68 percent of the net paid[1] amount of the denied inpatient claim. In the case of claims denied during prepayment review, CMS will make payment of 68 percent of the approximate amount[2] that would have been paid. These payments represent payment in full by Medicare. No further interest or other payments shall be made by Medicare.

2. In instances where a hospital has not fully repaid the originally denied claim amount, the hospital will receive payment of the percentage value applied less the outstanding overpayment balance. In instances where a hospital has not yet repaid any of the originally denied claim amount, or where the amount retained by a hospital exceeds 68 percent of the net paid amount, CMS will calculate the refund amount as the difference between the retained amount and 68 percent of the net paid amount. Any refund owed CMS will be subtracted from the overall payment under the Administrative Agreement, or from future Medicare payments to the hospital.

3. Billing or rebilling of specific claims is not required.

4. CMS payment for eligible claims that are resolved will be made in a single payment(s) (EFT or otherwise) per hospital provider number or per owner or operator of multiple settling hospitals (with affected provider numbers listed in an attachment to the administrative resolution agreement);

[1] CMS has specified net paid amount to allow the hospitals to receive a percentage of the payment on the original inpatient claim net paid amount. This excludes the out of pocket obligations which are included in the gross or allowable amounts.

[2] The approximate amount will be calculated based on the fee schedule, the hospitals zip code and the codes listed on the claim.

5. CMS makes payment within 60 days of hospitals entering into a fully executed Administrative Agreement. In instances where a refund is due CMS, the overall payment will be adjusted as specified in item 2 above.

6. Parties' obligations under the agreement become binding upon execution of the Administrative Agreement.

In order to participate in this process, the provider must review and agree to the settlement terms, and acknowledge such review and agreement through the Administrative Agreement document. This document shall be required by CMS in order to initiate the settlement process, and to suspend all pending appeals captured by the potential agreement. In addition, CMS is requiring each facility to complete a spreadsheet of claims it believes to be eligible for inclusion.

B. Eligible Providers and Claims

All of the following conditions must be met for claims to be eligible for settlement:

1. The provider is a hospital, as defined 1886(d) or §1820(c) of the Social Security Act. Accordingly, this process is offered to Critical Access hospitals and hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), but specifically excludes psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), cancer hospitals, and children's hospitals. CMS will permit hospitals paid under the authority of §1815(e) and §1814(b)(3) to participate, with the understanding that payments made will be adjusted according to the relevant statutory provisions.

2. The claim was not for items/services provided to a Medicare Part C enrollee

3. The claim was denied by an entity who conducted review on behalf of CMS (e.g., Medicare Administrative Contractor (MAC), Recovery Auditor, Comprehensive Error Rate Testing Contractor (CERT), Zone Program Integrity Contractor (ZPIC))

4. The claim was denied based on inappropriate patient status (or otherwise states that the services may have been reasonable and necessary but treatment on an inpatient basis was not)

5. The first day of admission was before October 1, 2013

6. The denial was timely appealed by the hospital:

As of the date the hospital signs and submits their first administrative agreement:

a. The appeal decision was still pending at the MAC, Qualified Independent Contractor (QIC), Administrative Law Judge (ALJ) or Departmental Appeals Board (DAB); or

b. The provider had not yet exhausted their appeal rights at the MAC, QIC, ALJ, or DAB levels

7. The provider did not receive payment for the services as a Part B claim ("rebill")

C. **Completion Instructions**

Each hospital that chooses to participate in this process must submit:

1. **A signed Administrative Agreement**
2. **An Eligible Claim Spreadsheet**

Note: If the hospital has multiple NPIs under one 6-digit Provider Number, the participant must submit a single Administrative Agreement and a single spreadsheet that includes all NPIs. If the participant has multiple Provider Numbers, they must submit a separate settlement request (including Administrative Agreement and Eligible Claim Spreadsheet) for each Provider Number.

Spreadsheet Header Data:

Field Name	**Requested Information**
Provider Name:	Provider Name as listed in the Centers for Medicare & Medicaid Services Enrollment System (PECOS)
Provider Number:	Provider Number (6-digit) — also known as the provider's CCN, OSCAR, or PTAN number
Provider Point of Contact	CMS is requesting a single point of contact from each participating provider (per spreadsheet) for us to contact with any questions/ concerns regarding data validation, etc. Please provide the name, email, and telephone number.
Provider State:	State
MAC Name:	Name of your current MAC: *Examples include Noridian Administrative Services (NAS), Novitas Solutions, Wisconsin Physician Services (WPS), National Government Services (NGS), Cahaba, Palmetto, First Coast Services Options FCSO) or Cigna Government Services (CGS).*

Mandatory Detailed Data

Column	Field Name	Requested Information
A	**Provider NPI:**	National Provider Identification (10-digit)
B	***DCN* Claim Number**	*List the DCN claim number, including all suffixes/letters on the end,* following the patient status review (or review to determine the appropriateness of inpatient admission as opposed to outpatient treatment) conducted by the MAC, Recovery Auditor, or other Medicare review contractor. *Note- This is found on the remittance advice that shows the claim adjustment.*
C	**Date of Admission (all must be prior to 10/1/13)**	List the date of Admission. Please note that this field is requesting the date of admission, not the date of service.
D	**CMS Medicare Review Contractor who issued initial denial**	Please indicate which type of CMS Medicare Review Contractor conducted the initial review and denial (such as the Recovery Auditor (e.g. Performant, CGI, Connolly, HDI), Medicare Administrative Contractor (e.g. Cahaba, Noridian), etc.)
E	**Appeal currently pending with or most recently reviewed at which level?**	Select one of the following: No Appeal; Redetermination by the Medicare Administrative Contractor (MAC); Reconsideration by the Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ) review; or Departmental Appeals Board (DAB) review
F	**Latest Pending or Adjudicated Appeal #**	If the claim has been sent for appeal and the appeal is still pending, please send the appeal number assigned by the current appeal entity. If the claim is not currently pending appeal, but is still within the timeframes to request review by the next level reviewer (i.e. if received QIC decision, still within 60 days to request ALJ review), then please provide the most recent appeal number assigned to the claim (in the prior example, that

		assigned by the QIC).
G	**If the appeal is pending at the ALJ/DAB, provide the date of the request for appeal**	Submit the date of the request for the Administrative Law Judge (ALJ) or Departmental Appeals Board review. Please provide the date in the DD/MM/YYYY format.
H	**Prepay or PostPay**	Select whether the claim was denied following prepayment or postpayment review
I	**Paid Part B Claim (Rebill)**	Has the claim been billed for Inpatient Part B/ Part B payment? (Yes/No)
J	**Appeal Previously Withdrawn or Dismissed?**	Was the appeal previously withdrawn or dismissed? (Yes/No)
K	**Original Inpatient Claim Paid Amount (PostPay) or Payable Amount (Prepay-- e.g. Pricer Amount)**	To be provided by CMS--no action needed by provider.
L	**Collected Amount**	To be provided by CMS--no action needed by provider.
M	**CMS Net Settlement Amount**	To be provided by CMS--no action needed by provider.
N	**Patient Status Review If changed due to appeal scope-- note in narrative**	To be provided by CMS--no action needed by provider.
O	**Disagreement Message**	To be provided by CMS--no action needed by provider.
P	**Claim Eligibility Determination**	To be provided by CMS--no action needed by provider.
Q	**Narrative Note**	To be provided by CMS--no action needed by provider.

D. Submission Instructions for Initial Settlement Request

Send to MedicareAppealsSettlement@cms.hhs.gov a single email (per Provider Number) that contains:

- A subject line that reads "Request for Settlement Agreement from [insert provider name]([insert 6 digit provider number]). For example: "Request for Settlement Agreement from General Hospital (123456)"
- a single signed Administrative Agreement in pdf format *(file name: PROVIDER NAME--6 DIGIT PROV NUM--ROUND ONE.PDF)*
- a single, completed excel spreadsheet (e.g. xls format) *(file name: PROVIDER NAME--6 DIGIT PROV NUM--ROUND ONE.XLS)*

CMS encourages hospitals to submit their initial settlement request on or before October 31, 2014.

Note: In order to ensure timely validation and payments being made, CMS encourages providers to complete all fields on the Eligible Claims Spreadsheet. If you do not complete all fields or utilize a different format, CMS will accept your submission. However, CMS cannot guarantee timely validation due to the need for additional research. This may delay CMS signing the Administrative Agreement. You may expect payment within 60 days of CMS executing the agreement, but you will experience a delay receiving the executed agreement.

E. Potentials List Request

Effective 10/15/2014, if a hospital is unable to produce a list of all eligible claims in a timely manner, the hospital may submit a request for a "Potentials List". CMS will respond within 2 business days with a list of POTENTIALLY eligible claims at Level 2 and above. This list will not include any claims that are still in process at the Medicare Administrative Contractor, but may include claims no longer eligible for one or more criteria. For example, the claim would not be eligible if the provider has already received payment for a Part B bill for the service. Providers who receive a "Potentials List" from CMS should review the list carefully and add or remove claims as needed prior to submitting the list to CMS as a full settlement request.
To request a "Potentials List" from CMS, providers will:

1. Send an email on or before October 31, 2014 to: MedicareAppealsSettlement@cms.hhs.gov.
2. The subject line of the e-mail should read: "Request for Potentials List from:
   - [insert provider name];
   - [insert 6 digit provider number]; and

- The body of the email should list each NPI associated with that Provider Number.