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Foulston Siefkin Health Care Issue Alert

CMS Offers to Settle Appeals of Denied Inpatient Claims for Hospital Stays Beginning Before October 31, 2013

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Is your hospital trudging its way through the seemingly endless levels of inpatient claims appeals? We have good news! Last week, due to the unprecedented backlog of appeals, CMS proposed to settle certain inpatient claims appeals for 68% of the claim.

On August 29, 2014, the Centers for Medicare and Medicaid Services issued a notice that it would settle appeals of denied claims involving inappropriate patient status determinations that are under appeal or within the allotted timeframe to request an appeal. CMS will settle qualifying appeals for 68% of the amount paid or the amount that would have been paid. To qualify, (1) the hospital must be a PPS hospital or critical access hospital, (2) the hospital admission must have occurred on or before October 31, 2013, (3) the claim must have been denied by an entity that conducted a review on behalf of CMS, (4) the claim must have been denied based on an inappropriate patient status, and (5) the hospital must have timely appealed the denial. The settlement offer is not available for items or services furnished to Medicare Part C enrollees or for psychiatric hospitals paid under the psychiatric PPS, inpatient rehab facilities, long-term care hospitals, cancer hospitals, or children's hospitals.

To obtain a settlement, the hospital must submit a signed administrative agreement and an eligible claim spreadsheet to MedicareAppealsSettlement@cms.hhs.gov. The required documentation must be submitted on or before October 31, 2014. If a hospital is unable to meet the October 31, 2014, deadline, the hospital should request an extension from CMS.

Upon receipt of the administrative agreement and claim spreadsheet, the appeals for claims referenced in the spreadsheet will be stayed, and CMS will confirm that the claims are eligible for settlement. CMS will pay the hospital a single lump sum within sixty days after it receives the required documentation and confirms the eligible claims. By signing the administrative agreement, the hospital agrees that the 68% payment is payment in full for the denied claims. The hospital will not receive any interest on the claims, and the hospital may not bill Medicare, any beneficiary, or any other payor any additional amount for the services.

To obtain a copy of the administrative agreement and settlement instructions, visit www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html.

For More Information
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