PUBLICATION

CMS Waves Partial White Flag in Appeals of Payment Status Denials [Ober|Kaler]

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For the last several years, hospitals, on the one hand, and the Centers for Medicare and Medicaid Services and its contractors (collectively, CMS), on the other, have been engaged in a spirited dispute over claims denials for allegedly inappropriate inpatient admissions. The Medicare contractors, by and large, did not challenge the reasonableness and necessity of the services being furnished by the hospitals, but instead contended that the services should have been furnished on an outpatient basis. The hospitals disagreed, and many appealed to the Department of Health and Human Services' Office of Medicare Hearings and Appeals (OMHA).

The hospitals' actions had two results. First, according to OMHA, the growth in claims appeals exceeded the adjudication resources available. As a consequence OMHA, in essence, put a hold on the processing of those appeals. Second, in the FFY 2014 IPPS final rule, CMS changed the standard for determining whether an inpatient admission was appropriate, creating the now applicable "two-midnight" rule in an effort to "clarify" matters. These actions, in turn, led to multiple lawsuits as well as criticism of the Department of Health and Human Services and CMS by both hospitals and Congress. CMS, however, has now taken a step that may alleviate some of this criticism, as well as the backlog of claims appeals.

In a notice that CMS put on its website on the Friday afternoon before the Labor Day weekend, CMS announced a new policy whereby it will offer administrative agreements to any hospital willing to withdraw its pending appeals in exchange for a timely partial payment of 68% of the net paid amount of each denied inpatient claim. The "net allowable amount" of each denied claim "means the payment on the original inpatient claim net paid amount," excluding any out-of-pocket obligations included in the "gross" or "allowable" amounts. CMS is extending this offer to acute care hospitals and critical access hospitals that have pending appeals of inpatient-status claims denials by Medicare contractors on the basis that the service, while it may have been reasonable and necessary, involved treatment that was not appropriate on an inpatient basis. The claims must involve a date of admission prior to October 1, 2013, and the patient must not have been a Medicare Part C enrollee. CMS has also stated that a hospital may not choose to settle some claims and continue to appeal others. Additionally, certain hospitals may be excluded from the settlement opportunity based on pending False Claims Act litigation or investigations. Finally, the hospital may not have received payment for the service as a Part B claim.

The CMS offer is time limited. **Hospitals must send their requests to CMS by October 31, 2014 or, if they are unable to meet this time frame, request an extension.** To make a request, the hospital is required to print, sign and scan a pdf version of an administrative agreement (which CMS has put on its website), follow the directions in the hospital participant settlement instructions (also posted on the website) and complete an eligible claims spreadsheet. The hospital must then email the package to a special site dealing with the Medicare appeals settlement.

Ober|Kaler's Comments

Many hospitals may find CMS's offer to be quite attractive, eliminating the time and expense associated with protracted claims appeal litigation as well as ensuring a prompt, if only partial, settlement. The devil in these matters, however, is often in the details, and the details are not as yet fully known. CMS has stated that there will be a teleconference on September 9 at which it will provide further information. Additionally, CMS will begin providing information on a Frequently Asked Questions site. Hospitals should stay tuned but, in the meantime, give the CMS offer their serious consideration.