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HEALTH LAW
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CMS Proposes Short-Term Inpatient Admission Settlement Process for Hospitals

On Friday, August 29, 2014, CMS announced that it was introducing a settlement process for pending appeals brought by acute care hospitals relating to short-term inpatient admissions occurring before October 1, 2013. According to CMS, the rationale for this settlement program is to reduce the backlog of pending appeals related to short-term inpatient admissions. Apparently, CMS believes that the CMS-1599-F rule, which modifies existing CMS policy with respect to how Medicare contractors should review short-term inpatient admissions (the "Rule"), will greatly reduce the number of pending appeals in the future. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Regulations.html.[1] Whether this is true given the significant controversy with respect to the Rule, the opportunity for hospitals to resolve pending appeals relating to short-term inpatient admissions prior to October 1, 2013 could benefit both hospitals and CMS.

Pursuant to the new CMS settlement process, CMS will pay 68% of the net value of the claim in exchange for the hospital's agreement to withdraw its administrative appeal. To participate in the settlement program, a hospital must file its request for settlement by October 31, 2014. According to CMS, claims are eligible for settlement only if: (i) the claim was denied by CMS; (ii) the patient was not enrolled in Medicare Part C; (iii) the treatment was medically necessary but did not qualify for an inpatient stay; (iv) the admission was before October 1, 2013; (v) the hospital timely filed an appeal and has not received any Part B reimbursement for the claim; and (vi) the appeal is still pending at the MAC, QIC, ALJ, or DAB levels of review, or the hospital had not yet exhausted its appeal rights at the MAC, QIC, ALJ, or DAB level. Claims that are subject to false claims investigation are not eligible for the settlement process.

1 The Rule provides that surgical procedures, diagnostic tests and other treatments (along with inpatient-only stays) are generally appropriate for inpatient admission and payment under Medicare Part A if: (i) the physician expects the beneficiary to require a stay that extends beyond at least two midnights; and (ii) the physician admits the patient with that expectation. The Rule also applies to outpatient observation services or services in an emergency department, operating room or other treatment area at the hospital to the extent that such time in such areas can be considered when determining whether the patient's stay spanned two midnights.

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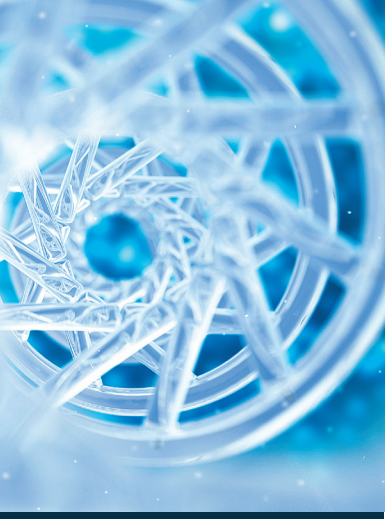

If a hospital chooses to settle all of its claims, it must complete and submit an Administrative Agreement and submit an excel spreadsheet of the claims at issue.[2] Once the Administrative Agreement is submitted to CMS, the claims are settled or a determination is made that the claims are not subject to settlement. After a reconciliation process with CMS, CMS will execute the Administrative Agreement and issue payment to the hospital within 60 days of the Administrative Agreement being finalized. If a hospital has not previously fully repaid the claim amount at issue, CMS will pay the hospital 68% of the claim less the outstanding overpayment balance. If the hospital has not repaid any of the claim amount at issue, the hospital will owe CMS the difference between the amount paid for the claim to the hospital and 68% of the net paid amount. While entering into the Administrative Agreement precludes the hospital from bringing any further appeals or looking to beneficiaries for any further payment (unless a repayment plan already exists), CMS may recoup any duplicate or incorrect payments made for claims pursuant to the Administrative Agreement that were inadvertently included in the settlement.

Whether or not settlement of a pending appeal is a good option for your hospital should be determined on a claim-by-claim basis. Nevertheless, the prospect of resolving these claims and having some resolution in the near future could be very beneficial to a hospital's bottom line. Of course, any decision to settle must take into account the hidden additional costs a hospital may have with its third-party contractors who have agreed to initially pursue these appeals. Given that it is very unlikely that the agreements that the hospitals have with these vendors include the possibility of a CMS settlement process, it may be necessary to pursue two settlement processes for resolution of these claims.

If you have any questions, please contact a member of Shipman & Goodwin's Health Law Practice Group.

2 This form can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/AdminstrativeAgreement.pdf

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