FREQUENTLY ASKED QUESTIONS

Low Volume Appeals (LVA) Process

Last Updated: January 4, 2018

A. GENERAL QUESTIONS:

1. What authority does CMS have to do this type of settlement?

CMS is creating this settlement opportunity pursuant to its compromise authority under the Social Security Act, including sections 1102, 1815, 1871, and 1893, and CMS's regulations regarding claims collection and compromise at 42 C.F.R. §§ 401.601 and 401.613, and regarding compromise of overpayments at 42 C.F.R. § 405.376, as well as the common law.

2. What is the deadline for an appellant to submit the Expression of Interest (EOI)?

For appellants with National Provider Identifiers (NPIs) ending in an even number (0, 2, 4, 6, 8), EOIs will be accepted on February 5, 2018 through March 9, 2018.

For appellants with **NPIs** ending in an **odd** number (1, 3, 5, 7, 9), EOIs will be accepted on March 12, 2018 through April 11, 2018.

3. Why are there two (2) EOI periods for the NPIs?

Due to the volume of appellants potentially eligible for this settlement process, CMS has divided the EOI period to help ensure the timely processing of all requests.

4. Can I submit multiple NPIs on one EOI?

No, each NPI must be submitted on a separate EOI to help ensure timely processing and easier payment tracking for the appellant.

5. What if an appellant has an odd and an even NPI, when does the appellant submit its EOI?

If an appellant has one even NPI and one odd NPI, the appellant must submit one EOI for the even NPI between February 5, 2018 and March 9, 2018. Then one EOI for the odd NPI between March 12, 2018 and April 11, 2018.

6. Is this settlement indicative of fault on behalf of CMS or the appellant requesting the settlement?

The parties will make no admission of fault or liability with regard to the administratively-resolved eligible appeals.

7. Who is authorized to sign the administrative agreement on behalf of the appellant?

The person who executes the administrative agreement represents and warrants that they are fully authorized to sign on behalf of the appellant.

8. How long will it take CMS to complete the settlement?

CMS and its contractors will work expeditiously to create the eligible appeal Spreadsheet. Once the appellant validates the Spreadsheet and returns the signed administrative agreement, CMS will countersign and effectuate payment within 180 days of CMS's countersignature.

9. How are Recovery Audit Contractor contingency fees impacted by this settlement offer?

Recovery Auditor contingency fees are governed by contract requirements and will be adjusted in accordance with such requirements.

10. What happens if we do not proceed with settlement after submitting an EOI?

The settlement participation is completely voluntary. Appellants who do not proceed with settlement after submitting an EOI will remain in the normal appeals process.

11. Will claims resolved through this type of settlement be excluded from future audits by any/all auditing entities, e.g., Medicare Administrative Contractor (MAC), Recovery Audit Contractor (RAC), Quality Improvement Organization (QIO), Supplemental Medical Review Contractor (SMRC), Comprehensive Error Rate Testing (CERT), Zone/Unified Program Integrity Contractor (ZPIC or UPIC), and Office of Inspector General (OIG)?

No, the claims resolved through this type of settlement will not necessarily be excluded from future audits. Claims that have already been reviewed are excluded from future review by a MAC and RAC. However, CERT reviews and reviews of potentially fraudulent claims will continue as appropriate.

12. Can appeals of extrapolated overpayments that otherwise meet eligibility criteria be settled under this process?

No, appeals resulting from extrapolated overpayments are not eligible for this settlement.

13. We have paid out a lot of money to appeal denials to the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (the Council). How can we recoup on this if we agree to take the settlement?

CMS cannot repay costs associated with an appeal. Nevertheless, this settlement opportunity eliminates any further administrative expense.

14. Why should I take a discount when I am likely to win the appeals I have filed?

CMS would encourage appellants to weigh the pros and cons of using this settlement option. Any appellant who is confident in a more advantageous outcome through the traditional appeals process may continue to pursue adjudication.

15. How will associated claims that are the subject of the administrative agreement be characterized in the relevant CMS database (such as the Common Working File)? Will they be characterized as paid claims? Denied claims?

Claims included in this settlement will remain denied and the appeals will be dismissed.

16. Is the settlement for both Medicare Fee-for-Service and Medicare Advantage cases in the appeal process?

This settlement is only for eligible claims submitted for payment under Medicare Fee-For-Service.

17. Will CMS share our administrative agreement with the public?

CMS may be required to disclose copies of executed administrative agreements or information contained therein in response to a lawful request. For example, with respect to the 2014 Hospital Appeal Settlement, CMS released the name, provider number, state, number of claims settled and amount paid to participating hospitals, in response to a Freedom of Information Act request.

18. Will appellants know the net settlement value of the included eligible appeals before they sign the administrative agreement?

No, the net settlement amount for an appellant will not be available before the agreement is signed. The net settlement amount will be determined after the settlement agreement has been signed by both parties. CMS's MACs price each claim individually. The settlement percentage will be 62% of the net claim approved amount.

19. From a process standpoint, what are some of the major steps?

Under this settlement process:

1. The appellant will submit an EOI.
2. CMS will provide a Spreadsheet of potentially eligible appeals and the associated claims to the appellant, along with an administrative agreement for the appellant to sign.
3. The appellant will validate the Spreadsheet of potentially eligible appeals and associated claims.

4. The appellant will sign the administrative agreement when it agrees to the Spreadsheet or submits an Eligibility Request Determination.
5. CMS will counter sign the Agreement.
6. The appeals will be stayed.
7. CMS's MACs will price the associated claims included in the Agreement after the Agreement has been signed by both parties.
8. CMS's MACs will issue one payment per settlement agreement within 180 days of CMS's signature on the Agreement.
9. The settled appeals will be dismissed.

20. Can I edit or add columns/fields to the eligible appeals Spreadsheet?

No, appellants may not add columns or reformat the Spreadsheet. If appellants make changes to the Spreadsheet, CMS will reject the Spreadsheet and the appellant will have to restart the EOI process.

21. Can I add or remove appeals from the eligible appeals Spreadsheet?

If the appellant wishes to add or remove appeals from the Spreadsheet, the appellant may submit an Eligibility Determination Request (EDR), which is available on CMS's appeals settlement website. CMS will review the EDR to make determinations on any necessary revisions to the Spreadsheet. The EDR process must be completed prior to signing the settlement agreement so that CMS is able to revalidate eligibility. Once the appellant signs the agreement, no appeals or associated claims can be added. CMS may remove appeals and associated claims during effectuation if CMS's MACs find that those appeals and associated claims did not, in fact, meet eligibility criteria. The appellant will be notified if appeals or associated claims are removed after the settlement is paid.

B. <u>ELIGIBILITY</u>:

1. Is the "fewer than 500 appeals" limitation applicable to each of my NPIs? What if I have multiple NPIs?

The "fewer than 500 appeals" limitation refers to the number of appeals, collectively, across all NPIs that belong to an appellant.

Example: If an appellant has 6 NPIs, and 100 appeals pending for each NPI, the appellant has 600 appeals pending and therefore is ineligible to participate in the LVA settlement process.

2. In order to participate, must an appellant have fewer than 500 appeals that have billed amounts of $9,000 or less? Or must an appellant have fewer than 500 appeals pending in total and, of those, CMS will settle the ones that have billed amounts of $9,000 or less?

This option is available for appellants with fewer than 500 appeals pending collectively at the OMHA *and* the Council. Once CMS confirms that an appellant has fewer than 500 appeals, CMS will settle those eligible appeals with total billed amounts of $9,000 or less.

Example: If an eligible appellant has 450 appeals pending at OMHA and 10 appeals pending at the Council, the appellant has 460 appeals pending collectively. If 400 of those 460 appeals have billed amounts of $1,000 each, but 60 of them have billed amounts of $10,000 each, CMS will settle the 400 appeals that have billed amounts of $1,000 each. The 60 appeals that have billed amounts of $10,000 each are ineligible for settlement as a part of the LVA process.

3. Does the "fewer than 500 appeals" limitation apply to appeals pending at the OMHA *and* the Council at the Departmental Appeals Board collectively? Or is the "fewer than 500 appeals" limitation applicable at each level?

This option is available for appellants with fewer than 500 appeals pending collectively at OMHA and the Council. In other words, if an appellant has appeals pending at both OMHA and the Council, the total number of appeals pending, in total, must be fewer than 500 appeals.

4. What appeals are eligible for settlement?

For purposes of the LVA settlement, an "eligible appeal" is defined as one meeting all elements of the following definition:

1) The appeal was pending before the OMHA and/or Council level of appeal as of November 3, 2017;
2) The appeal has a total billed amount of $9,000 or less;
3) The appeal was properly and timely filed at the OMHA or Council level as of November 3, 2017;
4) The claims included in the appeal were denied by a Medicare contractor and remain in a fully denied status in the Medicare system;
5) The claims included in the appeal were submitted for payment under Medicare Part A or Part B;
6) The claims included in the appeal were not part of an extrapolation; and
7) As of the date this Agreement is fully executed, the appeal was still pending at the OMHA or Council level of review.

5. Must an appellant settle all eligible appeals?

Yes, for the appellant to receive any payment as part of this settlement, the appellant must settle all ***eligible*** appeals for each NPI submitted. The appellant may not choose to settle some eligible appeals and continue to appeal others.

6. What date is CMS using to identify "currently pending appeals"?

CMS is using November 3, 2017 to determine currently pending appeals.

7. Is there a restriction or limitation for participation based on dates of service?

There is no specific restriction based on dates of service.

8. I just received a decision on an appeal that would otherwise meet the criteria for this settlement option. Could that appeal be included in this settlement?

No, if a decision is rendered on an appeal prior to execution of the Agreement, i.e., both parties have signed the agreement, the appeal is not eligible for settlement. For example, Provider X received an appeal decision on December 5, 2017. CMS and Provider X signed the LVA agreement on February 10, 2018. The appeals related to the decision rendered on December 5, 2017 are not eligible for settlement. Appeals not eligible for settlement remain in the traditional process.

9. If at some point in the process an appeal is determined to be ineligible for settlement, will I be allowed to continue the normal appeals process for that appeal?

Yes, you will be able to continue with the normal appeals process for appeals that are found to be ineligible.

10. Can appellants who otherwise meet the eligibility criteria be excluded from settlement by CMS?

Yes, certain appellants may be excluded from this process based on False Claims Act litigation or investigations, or other program integrity concerns, including pending civil, criminal, or administrative investigations. Appellants who have filed for bankruptcy or who expect to file for bankruptcy are also excluded from settlement. An appellant that is excluded from settlement will receive a letter from CMS notifying the appellant that it may not participate.

C. PROCESS:

1. Who is authorized to be the point of contact on the EOI?

The appellant may identify whomever it prefers to be the appellant's point of contact.

2. Will the appellant have the opportunity to review the final settlement amount before CMS effectuates the administrative agreement?

No, the appellant will not be able to review the final settlement amount before the administrative agreement is effectuated. The settlement amount will be calculated when CMS's MACs effectuate the signed settlement agreement and price each claim. Appellants will have a chance to review the final listing of eligible appeals before they sign the agreement.

3. How will the settlement affect the claim's history?

The claim will remain as denied and no claim-level adjustments will take place. A Medicare Summary notice (MSN) will not be sent to the beneficiary.

4. Is the 62% partial payment negotiable?

No, the settlement percentage is not negotiable.

5. Is the 62% settlement percentage calculated per associated claim or is the 62% applied to the sum of all the claims submitted?

The 62% is calculated per associated claim and then added together to be issued to the appellant in one lump sum payment. This payment could be netted against outstanding overpayments, which could result in no payment to the appellant.

6. In order to receive payment under this settlement, do appellants have to resubmit all the claims included in the settlement?

Appellants will not resubmit claims included in the settlement, nor will CMS's MACs reprocess any of the claims included in the settlement. The MACs will use the information on the final Spreadsheet the appellant agrees to, calculate 62% of each associated claim, and issue one lump sum net payment. Each claim will remain denied in the system.

7. How will payment be made? Will CMS clearly and specifically tell us which associated claims have been paid? How will the payment be handled, i.e. patient level or lump sum?

Payment will be made by CMS's with final claim payment information after effectuation of the agreement.

8. Do appellants still have appeal rights if they disagree with CMS's assessment?

Appellants may abandon the settlement process at any time prior to submitting the signed administrative agreement. Once the signed agreement is returned to CMS, appellants will no longer have an opportunity to appeal or otherwise dispute the inclusion or exclusion of appeals and their associated claims. Appellants who abandon the process at any time prior to submitting the signed administrative agreement will remain in the traditional appeals process.

9. Should the appeal Spreadsheet be sent securely since it includes Protected Health Information?

Yes, CMS will send the appellant an encrypted Spreadsheet. In turn, the appellant will send CMS an encrypted response.

10. How will other insurance payments in coordination of benefits situations be affected by the settlement agreement?

If the associated claim is included in the settlement, the appellant will receive 62% of the net approved amount, although the claims will remain as denied in CMS systems. An appellant's obligation to other payers will be determined by existing law and/or the appellant's existing arrangements or agreements with those other payers governing such situations.

11. How will payments be affected if the claim was for a dual-eligible beneficiary (Medicare and Medicaid)?

If the claim is included in the settlement, the appellant will receive 62% of the net approved amount. As an enrolled provider in a Medicaid program, the appellant has an obligation to notify the state Medicaid agency when they receive payment from another payer for care furnished to a dual-eligible beneficiary. Since the claim was denied, and will remain denied in CMS systems, Medicaid may have made payment. If so, the state Medicaid agency may recover any payment made, up to the amount paid for a claim resolved through this settlement.

12. Will I receive a new 835 remittance advice for claim appeals settled under this process?

Yes, the lump sum payment should appear on the remittance advice. Information about the specific claim line will be available on the final payment Spreadsheet.

13. I understand that the settlement is 62% of the net approved amount. What happens if I do not agree with the MAC's calculations of the net approved amount?

If you believe that there was a miscalculation on a specific claim associated with a settled appeal, contact your MAC regarding the calculation. MACs can review the accuracy of the calculations.

D. <u>APPEALS IMPACT</u>:

1. If I choose the settlement option, will I need to submit withdrawals for the pending appeals included in the settlement?

If an appellant executes a settlement agreement with CMS, the appellant agrees that all appeals included in the settlement will be dismissed. The appellant is not required to submit withdrawals for the appeals. OMHA and the Council will dismiss any applicable cases based on the finalized settlement agreement after notification from CMS. The finalized settlement

agreement serves as both the appellant's withdrawal of the eligible appeals and also as the dismissal of appeals by OMHA or the Council.

2. My Administrative Law Judge (ALJ) hearing is scheduled to occur during the eligibility timeframe for this settlement option and I want to pursue the settlement option. What should I do?

Each appellant may determine how it wishes to handle its scheduled hearings on an appeal by appeal basis.

If you choose to pursue the settlement option and wish to postpone a scheduled hearing, please contact the ALJ team assigned to hear your appeal and request a continuance in writing. State that you are requesting a continuance while you pursue resolution via CMS's Low Volume Appeals settlement option and send copies of that correspondence to all other parties to the appeal. Contact information for the ALJ team assigned to your appeal is available on the Notice of Hearing (see the top right-hand corner of the first page), or through the ALJ Appeal Status Information System (AASIS) found on the OMHA's website using either the Qualified Independent Contractor (QIC) or ALJ appeal number.

If you choose to pursue the settlement option and wish to attend your hearing as scheduled, you may do so until CMS receives your signed administrative agreement. Once CMS receives an appellant's signed administrative agreement, that appellant's eligible, active appeals will be moved to a "pended" status in the appeals management system shared by CMS and OMHA. When an appeal is moved to the "pended" status, the ALJ team will not be able to process the appeal further and no hearing will be conducted.

3. I filed an expression of interest for LVA but the appeals I have pending at OMHA were not ultimately resolved by the LVA process. Do I need to do anything to get my hearing scheduled?

If your appeals were not resolved via the LVA process, they will remain in an active status in the appeals management system shared by CMS and OMHA so no additional action is required on your part for OMHA to continue processing your appeal. However, if you previously requested in writing that an ALJ hold off on conducting a hearing in your case (a "continuance"), you should also contact the ALJ team in writing to confirm that you are no longer part of the LVA process and wish to go forward with scheduling a hearing. NOTE: If your appeal has not yet been assigned to an adjudicator, it will remain in the queue for assignment based on the date OMHA received your request for hearing.

4. Will I receive anything from OMHA or the Council when appeals included in the settlement are dismissed?

No. The finalized settlement agreement will serve as the procedural order of dismissal and notice described at 42 C.F.R § 405.1052(d) and 42 C.F.R. § 405.1114(a) for all settled appeals

pending with OMHA and the Council. OMHA and the Council will not issue separate orders or send any notices when the settled appeals are dismissed. The appellant will be responsible for notifying any non-participating parties that the settled appeals have been withdrawn and dismissed.

E. ABANDONING THE SETTLEMENT PROCESS :

1. What if the appellant wishes to withdraw from the settlement process?

The appellant may notify CMS that it wishes to abandon the settlement process at any point before submitting the signed administrative agreement. Once an appellant submits the signed administrative agreement, they may no longer withdraw from the settlement process. The appellant is also considered to have abandoned the process when it fails to respond to requests for information from CMS or its contractors within allotted timeframes prior to signing the administrative agreement.

F. PAYMENT:

Note: The term "net paid" refers to claims denied on post-payment review. The term "net payable" refers to claims denied on pre-payment review.

1. What is the appellant's refund responsibility related to the Beneficiary's co-insurance and deductible?

The appellant's refund responsibility is as follows:

a. If the beneficiary co-insurance has been collected at the time CMS signs the administrative agreement, no refund is required.
b. If the beneficiary co-insurance has not been collected at the time CMS signs the administrative agreement, the appellant must cease collections.
c. If a beneficiary repayment plan has been executed at the time CMS signs the administrative agreement, the appellant may continue to collect the co-insurance in accordance with the repayment plan.

2. What happens to recoupment of overpayments for claims that are in the appeal process that are part of the settlement request?

As part of the effectuation process, CMS's MACs will suspend recoupments.

3. What is the "Net Approved amount"?

"Net approved" equals the "bottom line" of the claim paid by Medicare after deductible and co-insurance.

G. INTEREST:

1. **Does the settlement agreement include repayment of full interest that has already been recouped from the appellants?**

Any interest the appellant paid after the claim was denied will be refunded. In addition, if interest has accrued that have not been paid, the accrued interest will be adjusted to zero. Each claim will be adjusted, and it will result in one lump sum payment made to the appellant.

2. **Will appellants receive interest for the claims under appeal?**

No, interest will not be paid for the claims under appeal. Settlement payment of 62% of the net approved amount will be "payment in full."

3. **If we participate in the settlement, do we get paid any interest owed for post-payment recoupments?**

No, interest will not be paid for the claims under appeal. Settlement payment of 62% of the net approved amount will be "payment in full."

4. **What resolution will the appellant have if the amount of interest recouped was not correctly applied to the settlement payment?**

If you believe that there was a miscalculation on recouped interest, contact your MAC. MACs can review the accuracy of the calculations.

H. COST REPORT:

1. **Please discuss whether the claims subject to administrative resolution will count toward an appellant's Medicare Part A percentage for Graduate Medical Education (GME) purposes.**

Claims will remain as denied in CMS systems and will not be included for cost report purposes, including the GME Medicare Part A percentage.

2. **How will this (the lump sum payment) be handled during cost report audits?**

Lump sum payment will not be included for cost report purposes, and claims will remain denied.

3. **Appellants may not bill beneficiaries for any unpaid cost-sharing amounts. What about uncollected deductibles/coinsurance due, may the appellant claim this as Medicare Bad Debt?**

The claims will remain as denied in CMS systems. The appellant may not claim the uncollected deductible/coinsurance from these settled claims as Medicare Bad Debt for cost reporting purposes.

4. **Since there is no rebilling involved, how will these settled claims appear in the appellants Provider Statistical & Reimbursement (PS&R) report?**

These claims will remain denied in CMS systems and will not be included on the PS&R or cost report.

5. **Will the inpatient days be reduced?**

No, total inpatient days will remain unchanged on the cost report.

6. **If we agree to the settlement, will this affect any other reimbursement or payment such as GME/Disproportionate Share Hospital (DSH) dollars?**

The claims will remain denied in CMS' systems. The data will not be used for cost reporting purposes.

7. **Since the claims will not be reprocessed, will this impact open cost reports, (DSH), or medical education?**

The claims will remain denied in CMS' systems. The data will not be used for cost reporting purposes.

8. **Will the Medicare Cost Report be impacted by the administrative agreement?**

No, the Medicare Cost Report will not be impacted by the administrative agreement. The administrative agreement results in one lump-sum payment (62% of the allowed amount) to the appellant. Claims and the cost reports will not be adjusted for any reason. This includes reimbursement for DSH payments, Indirect Medical Education, GME, and any other payments made on the cost report.