Critical Steps for Providers in the Appeals Settlement Process

Round 1:

1. Provider prepares Settlement Request based on CMS instructions (https://go.cms.gov/InpatientHospitalReview) to include:
    a. Administrative Agreement (.pdf)
    b. List of Eligible Claims (.xls)
2. Provider submits Settlement Request (both attachments) to CMS mailbox, MedicareAppealsSettlement@cms.hhs.gov.
3. Medicare Administrative Contractor (MAC) validates list of eligible claims submitted.
4. Upon completion of validation process, the MAC sends an email to the provider attaching Agreement and Disagreement spreadsheets, as applicable. (Note: Agreement spreadsheet will be locked, as it is not subject to editing. The Disagreement spreadsheet will not be locked, as the provider may add comments to the Narrative Note column).
5. Provider reviews pricing and sends an email (Reply All: MedicareAppealsSettlement@cms.hhs.gov) within 14 days to CMS indicating the decision to proceed with the settlement, or to abandon the process. Note: Pricing shown on the Agreement spreadsheet is non-negotiable.
6. CMS signs Administrative Agreement.
7. CMS sends hospital an email indicating the initial agreement has been fully executed, and the MAC will be notified to begin processing the Round 1 payment. The email will contain the following attachments:
    a. Claims List (.pdf)
    b. Fully executed Administrative Agreement (.pdf)
8. Prior to processing payment, the MAC will send a payment notification email to the provider. The MAC will then issue the payment.
9. The MAC sends a dismissal letter for each claim's appeal impacted in Round 1 of the settlement (within 60 days or less).

Round 2: If provider has a list of disagreements

1. Provider reviews the "Disagreement" spreadsheet and adds comments as needed to the Narrative Note Column.
2. Provider emails MedicareAppealsSettlement@cms.hhs.gov within 14 calendar days. The email must include the following documents:

    a. A second signed Administrative Agreement (.pdf) Document Name: [Provider Name-Provider Number-Round 2]
    b. List of revised/remaining eligible claims (.xls) Document Name: [Provider Name-Provider Number-Round 2]
3. The MAC reviews all Narrative Note comments for eligibility determination. This list will be compared to the original Round 1 Disagreement spreadsheet and any missing claims will be re-added. If the MAC has identified any eligible claims not previously submitted, they will be added at this time.
4. In order to distinguish claims where discussion is still needed, the MAC will add the following 3 tabs:
    a. Eligible Claims- Agree
    b. Ineligible Claims- Agree
    c. Unresolved (if applicable)

    All claims will be copied onto one of these tabs. The first tab will be a Master containing *all* claims, including claims that appear on the Eligible Claims- Agree, Ineligible Claims- Agree, and Unresolved tabs. Consensus is reached when there are no claims left on the Unresolved tab. At that point, the empty Unresolved tab will be deleted.
5. **For those providers *without* an Unresolved tab**, the Eligible claims will be priced. A locked Round 2 validated spreadsheet will be sent to the provider. The Round 2 payment will be the sum at the bottom of the column titled "CMS Net Settlement Amount".
6. CMS signs the second Administrative Agreement.
7. CMS sends the provider an email indicating the second Administrative Agreement has been fully executed, and the MAC will be notified to begin processing the Round 2 payment. The email will contain the following attachments:
    a. Claims List (.pdf)
    b. Fully executed Administrative Agreement (.pdf)
8. Prior to processing payment, the MAC will send a payment notification email to the provider. The MAC will then issue the payment.
9. The MAC sends a dismissal letter for each claim's appeal impacted in Round 2 of the settlement within 60 days or less.
10. All pended claims not included in the Round 1 or Round 2 Claims Lists (.pdf), will be reinstated with appropriate appeal timeframes.
11. **For those providers *with* an Unresolved tab**, the MAC will email the modified spreadsheet with instructions for supporting documentation submission. Per the instructions, you may be asked to submit documentation via email, or FAX, or either method. Note: all **email** submissions containing PHI must be submitted by a secure method, i.e. encryption.
12. Once the MAC has received the documentation, an email will be sent to the provider

confirming receipt.

13. The MAC will review all documentation, and adjust the claim(s) eligibility on the spreadsheet tabs as needed. If no claims remain on the Unresolved tab, the tab will be deleted.
14. If the MAC and provider have reached a consensus on all claims eligibility after the review of documentation, the process continues at #7, above.
15. If any unresolved claims remain after review of documentation, The MAC will call the Point of Contact designated for each provider. At this time the MAC may request specific information needed to determine a claim's eligibility, if not already submitted. If additional information can be supplied by the provider, the MAC will review. If the MAC and provider have reached a consensus on all claims eligibility after review of the documentation, the process continues at #7, above.
16. If any unresolved claims remain at this time, the MAC will contact CMS. The final determination on a claim's eligibility for settlement will be made by CMS.
17. The empty Unresolved tab will be deleted, and the process continues at #7, above.
18. All settled claims are subject to additional review at a later date to verify eligibility to be included in this settlement. As stated in the Administrative Agreement, CMS retains the right to recoup any duplicate or incorrect payments made for claims that were, but should not have been, included under this Agreement.