Appeal versus Settlement Checklist - Overview

In order to relieve the current backlog of claims in the appeals process, the Centers for Medicare & Medicaid Services (CMS) is offering acute care and critical access hospitals an opportunity to settle rather than pursue the appeals process. However, the decision to settle is not a simple undertaking. Many factors must be considered in determining the costs associated with the appeals process versus the amount of anticipated net revenue of these claims. While financial factors are significant drivers in determining whether or not to accept a settlement offer, we recognize there are other qualitative factors that drive decision making.

Provided here is an "Appeals versus Settlement Checklist" with a financial framework that hospitals may use to inform the decision-making process. Although not all inclusive due to the many variations and complexities of hospital operations, some of the considerations and factors captured in the checklist are included below.

As a first step in estimating the financial impact of the settlement, a hospital must identify the universe of claims that it must include if it pursues settlement. CMS has offered the settlement **only** for claims denials made on the basis of patient status – that is, cases where a Medicare contractor denied the claim on the basis that the inpatient care should have been delivered in an outpatient setting – and **only** for claims with an admission date prior to Oct. 1, 2013. Additionally, the offer is not limited to Recovery Audit Contractor (RAC) denials – it also includes Medicare Administrative Contractor, Comprehensive Error Rate Testing Contractor and Zone Program Integrity Contractor denials. Any claim that is either pending at the Medicare Administrative Contractor, Qualified Independent Contractor, administrative law judge (ALJ) or Departmental Appeals Board level, or for which the hospital is within its appeal timeframe, will be included in the settlement.

In thinking through whether to pursue the settlement, hospitals should:

1. **Determine the success rate of historic appeals.** Is the same success rate expected in the future? For example, has the hospital implemented improvements – such as a documentation improvement program – that may result in a higher success rate in the appeals process?
2. **Calculate the interest due on denials for which a favorable ALJ decision is anticipated.** Statute requires CMS to allow hospitals to delay recoupment of denied claims until after a Qualified Independent Contractor denial at the second stage of appeal (also known as a 935 recoupment). A hospital that did not voluntarily repay denied claims, and thus was subject to mandatory recoupment, would be due interest on the recouped funds if it receives a favorable ALJ decision on its appeal.
3. **Calculate the historic costs associated with the appeals process (see Schedule A of the checklist).** There are many costs that are associated with the Medicare appeals process. Some of these costs may be direct, such as outside attorney fees or contractor and consultant costs. The hospital also may

incur indirect costs, such as internal clerical and clinical staff that have a part-time role in the appeals process.

4. **Estimate future costs.** When evaluating the portfolio of accounts in appeals status, certain accounts are in various stages of the appeal process. It is important to estimate what additional costs are going to be incurred if the hospital were to decline the settlement and continue pursuing its appeals.
5. **Consider the effect, over time, on cash-flow delays due to the appeals process.** Hospitals should calculate the Net Present Value (NPV) of the hospital's net revenue of claims in appeal to reflect the time cost of money (i.e., working through the appeals process over time versus taking the settlement now).

Finally, there may be other factors to consider depending on the hospital and its available resources and priorities. Nonetheless, making the decision to appeal or to settle should be considered carefully. The attached checklist is provided to assist hospitals in determining whether to pursue CMS's settlement offer.

Appeal versus Settlement Checklist
Summary

Net Revenue Calculation

	Total
Revenue	
Net Revenue of Claims in Appeal Status	$ -
Historic Success Rate *	0%
Anticipated Net Revenue *(Historic Success Rate x Net Revenue in Appeal Status)*	$ -
Interest from overturned appeals	$ -
Costs *(From Schedule A) **	
Historic	$ -
Anticipated Future	$ -
Total Anticipated Costs	$ -
Net Realizable Revenue *(Anticipated Net Revenue, less Total Anticipated Costs)*	$ -

Hospital's Current Net Revenue *(Based on historical success rate, and the historic/future costs)*	**$ -**

** If something in your environment has changed to indicate more/less favorable appeal success rate, factor into calculation.*

*** Given your hospital's environment for the portion of claims in appeal, there could be additional costs - refer to Schedule A for consideration.*

Settlement Revenue Calculation (at $.68 on the dollar)

Total Net Revenue in Appeal Status *(Pulled from Total column above)*	$ -
Settlement Revenue *(Total Net Revenue in Appeal Status x $.68)*	$ -
Total Historic Costs *(From Schedule A)*	$ -
Total Net Settlement Revenue *(Settlement Revenue, less Total Historic Costs)*	$ -

Appeal vs. Settlement

If the Hospital's Current Net Revenue is:

- **greater than** the Total Net Settlement Revenue: calculate the NPV to help determine whether to pursue the settlement or continue the appeal process.
- **equal to or less than** the Total Net Settlement Revenue: consider pursuing the CMS Settlement.

This checklist is not all inclusive, but is intended as a tool to identify some of the items to consider when contemplating pursuing the CMS settlement for claims in appeal. Other factors may need consideration depending on the hospital's available resources and its priorities.

Schedule A

Breakdown of Costs

	Historic Cost	Estimated Future Cost*	Total
Outside Counsel / Attorney Fees	$ -	$ -	$ -
Outside Contractor/Consultant Costs	$ -	$ -	$ -
Other:	$ -	$ -	$ -
Internal			
Counsel / Attorney Fees	$ -	$ -	$ -
Physician Advisor	$ -	$ -	$ -
Clinical Appeal Coordinator	$ -	$ -	$ -
Appeal Tracking Software Costs	$ -	$ -	$ -
Clerical Costs	$ -	$ -	$ -
Other:	$ -	$ -	$ -
Grand Total	$ -	$ -	$ -

*It is suggested that this number be calculated in the aggregate and isn't necessary at the line item cost level.