IRF Appeals Settlement Initiative Call

Moderated by: Hazeline Roulac
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Hazeline Roulac. Thank you. You may begin.

Announcements & Introduction

Hazeline Roulac: Thank you, Dorothy. Hello, everyone. I am Hazeline Roulac from the Provider Communications Group here at CMS and I am your moderator today. I would like to welcome you to this Medicare Learning Network call on Inpatient Rehabilitation Facility Appeals Settlement Initiative.

CMS is accepting Expressions of Interest for settlement option for Inpatient Rehab Facility Appeal pending at the Medicare Administrative Contractor or MAC, the Qualified Independent Contractor or QIC, the Office of Medicare Hearings and Appeals or OMHA and/or Medicare Appeals Council Levels of Review. During this call, we will review the appellant eligibility, Expression of Interest period and settlement process, and frequently asked questions. A question and answer session follows the presentation.

During the registration process, you were able to submit questions in advance of this call. We thank those who submitted questions. Our subject matter experts will respond to these questions at the start of the Q&A portion of this call.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.CMS.gov/npc. Again, that URL is go.CMS.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question and answer session. If you have inquiries, please email press@cms.hhs.gov. That's press@cms.hhs.gov.

At this time, I would like to introduce our subject matter experts for today's discussion. We have Suzanne Mattes, Director of the Division of Medicare Debt Resolution. And joining Suzanne are Cyndy Ginsberg and Nicholas Martin, both Health Insurance Specialists in the division. Also joining us today is Cherise Neville, Senior Attorney Settlement Conference Facilitation Program Coordinator from the Office of Medicare Hearings and Appeals.

At this time, I am pleased to turn the call over to Suzanne Mattes. Suzanne?

Presentation

Suzanne Mattes: Thanks, Hazeline. Good afternoon. Thanks for joining us today. Just one quick housekeeping item before we begin. If you find any inconsistencies between what we discussed here today and the information on our website, we ask that you refer to the website, the website will control.

As always though, feel free to email the Medicare Appeals Settlement mailbox with any questions or concerns. CMS has established the IRF Appeal Settlement Process as part of the broader Department of Health and Human Services commitment to improving the Medicare appeals process and reducing the appeals backlog.

The settlement option will be geared or is geared toward certain IRF appeals pending at any of the administrative levels of review. We're also including appeals that are in between levels but are still eligible for appeal to the next level. Appellants that filed IRF appeals at the redetermination level no later than August 31, 2018, have the option to settle their eligible appeals as follows.

CMS will pay 69% of the net payable amount for all claims associated with pending IRF appeals that do not otherwise meet the criteria for Intensity of Therapy appeals that I'll reference immediately.

The Intensity of Therapy appeals-- for intensive therapy appeals CMS will pay 100% of the net payable amount for all IRF appeals in which the claim was denied based solely — solely on a threshold of therapy time not being met where the claim did not undergo further review for medical necessity of the intensive rehabilitation therapy program based on the individual facts of the case.

Further, CMS will pay 100% of the net payable amount for all IRF appeals in which the claim is denied solely because the justification for group therapy was not documented in the medical record. We'll talk a little bit about how this part of the process works in just a few minutes, how you're actually able to apply for that percentage and get a decision on that.

Eligible Appeals

We'll move to slide 5 and talk a little bit about eligible appeals and how you're able to tell whether appeals that you may have pending in the backlog right now are eligible.

An IRF appeal is eligible if it is either currently pending or within the timely filing period to appeal at the MAC, QIC, OMHA, or Council levels of appeal as of the date of CMS's signature on the settlement agreement.

It's also eligible if it was correctly and timely filed at its most recent level of appeal, it was filed with the MAC for redetermination no later than August 31, 2018, it includes only claims that were fully denied by a Medicare contractor and remain in a fully denied status, it does not include claims that were part of an extrapolation, it was not beneficiary initiated, the beneficiary was not found liable for the amount in controversy after the initial determination or participating in the reconsideration, it does not involve items, services, drugs or biologicals billed under unlisted, unspecified, unclassified or miscellaneous healthcare code, it does not arise from a MAC, QIC, ALJ or Council dismissal order, and it includes Part A IRF claims only.

Now I have to emphasize that it has to meet all of those eligibility requirements in order for an appeal to be eligible for this process. Let's talk really quickly about appellant eligibility. It's a lot easier for us to talk about which appellants are ineligible rather than the ones that are eligible.

So, ineligible appellants include Medicare beneficiaries, Medicare Advantage plan enrollees, their family members or states, State Medicaid Agencies, Medicare Advantage Organizations, IRFs that filed for bankruptcy or expect to file for bankruptcy.

And we would also know that certain appellants that are or were involved in false claims act litigations or investigations or those that have other program integrity concerns including pending civil, criminal or administrative investigations may be precluded from participating.

Initiating Settlement

We're going to jump to slide 7 and talk a little bit about how to actually participate in this process, that's really the meat of this presentation. If you -- if all this sounds really good to you and you want to initiate the participation in settlement for this, we ask that you submit an Expression of Interest to CMS at MedicareAppealsSettlement@CMS.hhs.gov

This is the same email address that we were using for questions for this call. I know in the presentation there is a typo. So, it is the same email address that we used for questions for this call and it is referenced on the website as well. And I would also note that we triage emails based on the subject lines. So, make sure that you're including information in the subject line that indicates that this is an EOI for the IRF Appeals Settlement Initiative and the name of the appellant.

All of this information as well as the EOI document can be found at go.CMS.gov/irf. And we'll be accepting EOI through September 17, 2019. Once we receive the EOI we will verify that you meet appellant eligibility criteria and that you have eligible appeals. If you don't meet eligibility criteria or you don't have eligible appeals, we'll let you know within 30 days of submitting your Expression of Interest

If you do, in fact, pass the eligibility review, you will receive an administrative settlement agreement and a spreadsheet that will include what we believe are potentially eligible appeals within 30 days of submitting your EOI. As we move to slide 9, we'll talk more about the settlement process.

Once you receive the agreement and the spreadsheet and you actually have a chance to review the spreadsheet and agree with the appeals that are included on it, sign it and return it to us within 15 days of the date that you receive the spreadsheet and the agreement.

If you don't agree with the appeals that are on the spreadsheet, then you're able to submit an Eligibility Determination Request. So, that we're able to review whether appeals that you believe should be included, should in fact be included and whether you-- appeals that you've identified as appeals that should be removed from the process should be removed. We ask that you do that within 15 days as well.

This is also the process that you would use if you believe that you have appeals that meet the criteria for the 100% of net payable amount. The Eligibility Determination Request can -- is really designed to be used to add or remove appeals if you believe that somehow, we have either missed something, overlooked something, or included something that we shouldn't have included.

The EDR template with the instructions is available on our website, go.CMS.gov/irf. And the completed EDR should be submitted to us again within 15 days of receiving your agreement and spreadsheet. So, you're either returning the signed agreement itself within 15 days or you're submitting an EDR within 15 days.

If you submit an EDR, then we and you the appellant and the Medicare Administrative Contractor will work together to come to a consensus on the appeals that should be included on the spreadsheet. And the goal for us is to do that within 30 days. And that's within 30 days of you submitting your request for EDR.

Now I would point out that depending on whether there is back and forth between the Medicare Administrative Contractor and the appellants that the time-frame can move a little bit, but the goal, the ultimate goal is to get that resolved as quickly as we can and we shoot for making sure that that's completed within 30 days.

I would also note that we, CMS retain the right to make the final eligibility decision and with that I would also note just to keep in mind that any appeals that aren't settled here will return to their place in the queue for hearing. One last point of note, only one EDR may be submitted per NPI. This helps us stay organized with the information that's coming in the door.

As we move to slide 11, a few more notes about the settlement process. You must settle all eligible appeals. You aren't able to choose which ones you settle and choose different ones to continue through the appeals process. If we identify ones that are in fact eligible, they have to be included in the settlement.

Failure to provide a signed agreement or EDR to CMS within 15 days of receipt of the agreement and spreadsheet will result in removing you from the settlement process. We're really trying to maintain our ability to expedite these as quickly as we can, so we ask that you do your best to adhere to the time frames we're asking you to adhere to.

Moving to slide 12. Once we receive your signed agreement and spreadsheet, CMS countersigns the agreement. We'll then issue you, the appellant, a fully executed agreement and at that point your appeals that we've included in the spreadsheet will be removed from the appeals queue.

A copy of the fully executed agreement is then sent to the appropriate MAC for final eligibility verification and pricing. There is a possibility that during that final validation that the MAC performs that appeals and associated claims may be removed from the settlement for not meeting certain eligibility criteria. If that happens - if that happens, you will be notified.

The MAC will actually reach out to you and make sure that you're aware of what's going on. Payment will be made within 180 days of CMS's signature on the agreement. And the appeals associated with settled claims will be dismissed and appeals associated with unsettled claims, if any, will be returned to their position in the appeals queue to continue in the appeals process.

That actually concludes the presentation. We tried to hit the high-level points of how this process works. And I will now turn it back over to Hazeline so that we can open the lines for questions and answers.

Question & Answer Session

Hazeline Roulac: Thank you, Suzanne. Before we get started with taking your questions, Suzanne is going to address several questions that were received in advance of the call and then we will open the lines for your questions. Suzanne?

Suzanne Mattes: Perfect. Thank you.

The 1st question we received is this. It's regarding extrapolations. If some denials are overturned, are the remaining claims eligible for IRF? The answer to that is no. Any claims that are part of extrapolations, either the sample or the universe, are not eligible for this particular process.

The 2nd question we received is as follows; what if there's disagreement with the spreadsheet, missing appeals or no appeals, etcetera?

The EDR process, the Eligibility Determination Request process, is actually designed to specifically address that, and I know we talked about it briefly here. If you have any other questions about how that process works, feel free to reach out to us through the mailbox.

The 3rd question we received relates to deactivated NPI's and/or PTAN's and whether they are eligible for this particular process. And unfortunately, we aren't able to speak specifically on whether a particular NPI-PTAN combination is eligible. But if it's voluntarily deactivated and there are no program integrity issues, then the deactivation shouldn't matter.

Just keep in mind that payment is made based on that NPI-PTAN combo, that's how and where the MACs determine where they're going to issue payment. So, if you have that particular problem or concern, rather, then we certainly encourage you to work with the MAC that would be making payment. If that isn't feasible for you, then reach out to us and we'll help facilitate those discussions. Let's see.

Does CMS expect or require the providers to submit an Eligibility Determination Request for the claims that would qualify under one of the Intensity of Therapy exceptions that are to receive 100%? Does this mean that even though the claims will be included on CMS's listing in response to the Expression of Interest they will not be identifiable by CMS or the MAC as one of the 100% exceptions without the providers subsequently submitting an EDR?

The short answer to that question is yes. So, when we're pulling the appeals and we're identifying them on the spreadsheet we don't necessarily know whether they qualify for that particular criteria. We don't have the specific details at least in front of us at that time on what the denial reasons were specifically.

So, what we are asking of you is if you believe that there are appeals on your spreadsheet that meet those criteria -- any of the criteria that you annotated in the column, there's a call specifically identified for that particular situation. When you send that EDR back to us the Medicare Administrative Contractor will actually do the research to determine whether the criteria are met.

If you happen to have documentation that speaks to the issue and you're able to provide it, we welcome it. That will certainly expedite any of the review that the MAC has to perform. If you don't have it, then the MAC will review the documentation that it has available to determine whether those criteria are met.

The 5th question we received, does the IRF claim appeal settlement offer include prepay audit cases under appeal as well as post-pay audit cases. And the answer to that is yes. Any appeals that meet the eligibility criteria will be included regardless of whether they were prepay or post-pay denials. The only real exception or obvious exception is the extrapolated overpayments.

The 6th question we received, once you submit an Eligibility Determination Request what is the anticipated timeline before you receive a response with an updated EOI appeal spreadsheet. We definitely process those in the order in which they are received and the target as I mentioned earlier in the call is that we resolve those within 30 days.

So, you should hear back from the Medicare Administrative Contractor fairly, fairly quickly if the idea is that we want to give you the opportunity to actually review the responses from the MAC's and then respond again accordingly. But, ultimately the time frame that we're able to provide for you is that we expect to try to have this resolved within 30 days from the date you submit your EDR request.

The 7th question we received related to EOIs. We've had a few situations where we've actually returned Expressions of Interest and the person who asked this question asked how and why and how do we make sure that doesn't happen again? We ask that appellant actually type the information into the Expression of Interest.

So, one of the reasons that EOI's are returned is because we either maybe can't read them if they were handwritten, we will do our best. But at minimum we ask that the NPI is typed, that is the primary, that's the main thing that we use to link all of the appeals and to actually do our searches. We need to ensure that that's correct.

So, we ask that you type the NPI. We've also received a few Expressions of Interest that weren't signed, and we will return Expressions of Interest that are not signed. So, we ask that you make sure that they're signed and typed if possible.

Let's see. The last question that we received, is it true that when an appellant agrees to settle the denied cases or claims through the settlement process, the RAC MAC serve or any other governmental auditor can re-review and can deny the same cases or claims, if so, why?

We think we understand the concern here if we misunderstand the concern then please feel free to reach out again to us through the mailbox and we'll do our best to address the concern. But here we believe that the concern is related to whether CMS in theory could actually rescind payment for these claims based on some type of subsequent review.

We just want to know the CMS would make payment on these claims, but the claims themselves would remain denied in our system. Denying them in the future or denying them again is actually impossible because the claim status will still be denied.

We tried to address this concern. It was actually raised earlier in our developmental process when we put the settlement agreement together and we tried to address this by stating that the settlement parties understand that CMS is payment for claims identified in the attached spreadsheet is final.

Our intention here really is to ensure that if we reach settlement on this, that the payments themselves, once we make them, they are final and that the claims remain denied in the system.

Unfortunately, other than that we are unable to speak to whether any of the auditing entities would audit or re-review for some reason. And just a couple of other things quickly before we open the lines. We had a few

questions come in the door regarding hearings that were scheduled with Administrative Law Judges and I will ask my colleague, Cherise Neville, to speak to that issue.

Cherise Neville: So, hi everyone. This is Cherise Neville from the Office of Medicare Hearings and Appeals. Just so that everyone understands OMHA ALJs were informed that all pending OMHA IRF appeals, regardless of hearing status, could be subject to the IRF initiative.

All OMHA staffs have been encouraged to work with individual appellants or the representatives as appropriate to address the circumstances of each case, in the event that an appellant request a postponement of a hearing, for example. Notwithstanding, appellants do not have the right to postpone a hearing. The appellant can request an action and a decision regarding how to proceed as a matter left to the ALJ.

Suzanne Mattes: Thanks, Cherise. We really appreciate your input on that one. With that I'll turn it back over to Hazeline and we'll get ready for some live questions and answers.

Hazeline Roulac: Thank you, Suzanne. We will open the phone lines now for your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many questions as possible each caller is limited to one question at a time.

To allow more participants the opportunity to ask questions, please send questions specific to your particular organization to the resource mailbox on slide 15 so our staff can do more research. During this call, preference will be given to general questions applicable to a larger audience, and we will be mindful of the time spent on each question. All right, Dorothy, we are ready for our first caller.

Operator: To ask a question press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question, to assure clarity. Once your line is open, state your name and organization. Please note, your line will remain open during the time you are asking your question, so anything you say, or any background noise, will be heard in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Andrew Thompson.

Andrene Thompson: Hello! This is Andrea Thompson calling from St. Francis Hospital in Tulsa, Oklahoma. And so, I received my administrative settlement agreement email, but I did not receive a spreadsheet. I sent back an email, but I haven't received a response.

Suzanne Mattes: Okay. Thank you. We will look into that for you and respond to you personally on that issue.

Andrene Thompson: Okay. Thank you.

Suzanne Mattes: Sure.

Operator: Your next question comes from a line of Mary Myslajek.

Mary Myslajek: Thank you. It's Mary Myslajek from Hennepin Healthcare. My question has to do with the extrapolation, and I understand that claims subject to extrapolation are not eligible for this settlement. I'm asking is it possible for an entity to waive their right to the extrapolation and therefore come under the settlement.

Suzanne Mattes: Unfortunately, the answer to that is no. We are looking exclusively at the appeals as we are pulling them based on the NPI that's provided. And we would automatically be excluding any of the appeals that we pull that indicate that they're part of an extrapolation. Unfortunately, that's not something we're able to modify at this point.

Mary Myslajek: Okay. Thank you. Thank you for the information.

Suzanne Mattes: Sure.

Operator: Your next question comes from a line of Debra Schultz.

Debra Schultz: Hi! This is Debbie Schultz from Casa Colina Hospital. I'm asking the question regarding we submitted an Expression of Interest back in June and we have not gotten any response within the 30 days or a spreadsheet. Who do we contact to confirm that they in fact did receive it and why we haven't received information within that time frame?

Suzanne Mattes: Well, we're certainly sorry to hear that. If you send something to the Medicare appeal settlement mailbox and include that information in it, the folks in this room will actually be able to take a look at it specifically and address that.

Debra Schultz: Okay, so the CMSMedicareappealssettlement@CMS, that's the address you're talking about?

Suzanne Mattes: Yeah, it's MedicareAppealsSettlement@cms.hhs.gov.

Debra Schultz: Thank you.

Suzanne Mattes: Absolutely.

Operator: Your next question comes from the line of Christina Hughes.

Christina Hughes: Hi! This is Christina Hughes from Powers, Pyles, Sutter, & Verville. With respect to the EDR and submitting claims for consideration under settlement for the intensity of therapy, you mentioned that if we can provide supporting documentation that's helpful and I was curious what kind of supporting documentation would you accept, particularly in light of the fact that the documents specifically say that PHI should not be submitted to the settlement process.

Suzanne Mattes: That's a good question. Generally, what we're looking for is the actual denial letters themselves. It's our understanding that there has been - have been circumstances where this specific language was included in either the redetermination denial or perhaps the claim denial itself.

So, anything like that you have would give our MAC's a leg up in terms of processing. If you had some concerns about submitting it because it's related to PHI, then what we would ask you to do is encrypt it or reach out to us through the mailbox and we'll work with you to make sure that you're able to get that information to us in the most appropriate way.

Christina Hughes: Thank you.

Operator: Your next question comes from the line of Jane Mansusky.

Jane Mansusky: Yes, this is Jane Mansusky from Post-Acute Advisors. And my question has to do with denials for which Part B services were billed, and are those still eligible for the settlement?

Suzanne Mattes: The only claims that will be paid are Part A IRF services. So, if it was submitted as a Part B it wasn't necessarily our intention to include it in the spreadsheet.

Cyndy Ginsburg: It wouldn't be on the spreadsheet.

Suzanne Mattes: There's something else that if you don't mind sending to the mailbox, we can confirm what the most appropriate way that we are handling that should be.

Jane Mansusky: We sent it to the mailbox, but we haven't received a response yet.

Suzanne Mattes: Okay. Please make sure that you sent it to MedicareAppealsSettlement@cms.hhs.gov, that's the mailbox that comes directly here to my folks here in this office.

Jane Mansusky: Yes, ma'am.

Suzanne Mattes: Thank you.

Operator: Your next question comes from the line of James Blanton.

James Blanton: Yes. We've sent in our letter of Interest, but we also have about five cases I think scheduled for early September, should we just proceed on those as usual and -- ?

Cherise Neville: Hi! This is Cherise Neville. If you received a notice of hearing, you should plan on attending that hearing. You can send in a request to the ALJ for postponement and just explain that you're going through the IRF initiative process, but it is that the ALJ's discretion whether to grant a request for postponement or to continue with the hearing.

James Blanton: Okay. Thank you.

Operator: Your next question comes from the line of Nicole McKinney.

Nicole McKinney: Hi! We submitted our EDR after I received my initial spreadsheet and I submitted my EDR, I just included the cases were left off and I received a response saying this is my new spreadsheet; however, it

didn't include all the initial cases. Does the EDR need to include all of the cases eligible? I took it as the response just needed to be the one that I thought were missing.

Suzanne Mattes: Hold on, we're going to talk among ourselves a second.

Nicole McKinney: I'm so sorry. I was having some major phone issues there. I submitted our Interest and I received my spreadsheet back. I submitted an EDR with just the cases I thought were missing. And I received a new response saying this is your new spreadsheet and it only address the 13 I submitted I thought were missing, not the initial batch. Does EDR need to include all of the cases?

Suzanne Mattes: The EDR did not need to. When you submitted your EDR based on what you're telling me it sounds like you did it exactly the way that you were supposed to do it. The response that you should have gotten should have been an entirely – an entire spreadsheet.

So, if for example, you had identified ones that you believe that were missing from the spreadsheet what you should have gotten is the original spreadsheet plus those. If that is not what you received, then I'm probably starting to sound like a broken record, I'm sorry for that, but please reach out to us that MedicareAppealsSettlement@cms.hhs.gov. and we'll investigate what's going on.

Nicole McKinney: All right. Great. Thank you.

Operator: Your next question comes from the line of Kelly Walsh.

Kelly Walsh: Hi! This is Kelly Walsh. And I just have a question. I have not done an Expression of Interest yet. We're still trying to make that decision. And if I understand this process when we do that, we're going to submit a spreadsheet with all those appeals that we believe meet the criteria.

You are going to go through and make sure they meet basically the criteria for the settlement and respond to us, but you're not going to tell us whether they are a 100% payable, or they are a 69% payable. And after we get your reply if we think some are at a 100%, we would then need to do the EDR outlining which ones we believe are 100%. Do I understand that correctly or am I saying that wrong?

Suzanne Mattes: You're most of the way there, but it's actually a little bit easier than what you described. In order to start the process, you actually just have to submit the Expression of Interest document. It's basically a document that tells us who the appellant is and what the NPI is. We will pull a spreadsheet for you.

When we provide it for you have the opportunity to review it. We ask that you really buckle down and try to review it and get back to us within 15 days. If you agree with it, you can actually sign the agreement at that time and return it to us, we'll go straight to payment.

If you don't agree with it, you think things are missing from it or you think we have included things that shouldn't be included or you believe that there are ones on there that meet the criteria for 100%, you just - you put those appeals on that spreadsheet and you annotate it.

There's actually a column for potentially eligible, it's labeled potentially eligible, potentially ineligible or 100%. And you can just put X's in the columns next to the appeals that you'd like us to review.

Kelly Walsh: Okay.

Suzanne Mattes: Once we do that for you, you have a chance to take another look and you can either sign the agreement. If you have more questions, you can come back to us.

Kelly Walsh: Okay. So, when you send that to me, the spreadsheet, that's when I'm going to review it and I'm going to determine if I believe any of them are at a 100%. And if they are, I check that 100% column.

Suzanne Mattes: Right.

Kelly Walsh: And then the other ones would just be, if I believe they all I would do that potentially eligible. And if I have documentation related to the denial for those 100% that's when I would send that documentation back with that spreadsheet.

Suzanne Mattes: The only thing that you have to identify for us is if we've gotten something incorrect. So, if most of your spreadsheet is right and you have no issues with it at all, but you two that are on the spreadsheet that you believe are eligible for 100%, you send those two appeals to us on the EDR document, on the EDR spreadsheet and mark the 100% column, and we'll take a look at. Everything else will stay the same. You don't have to do anything with the ones that look good to you.

Kelly Walsh: Okay. And then you'll return it to me and let me know yes you agree and that's when I can sign off and say yes, I want to continue forward, is that correct?

Suzanne Mattes: You got it. Yes.

Kelly Walsh: Thank you.

Operator: Your next question comes from the line of Lisa Moser.

Lisa Moser: Hi! This is Lisa Moser from Virginia Baptist. My question is regarding the form itself. I'm having issues finding an active appeal number because some of those were still stuck in level one. Is that going to be an issue for denying up the spreadsheet as long as I have the DCN claim number on there?

Suzanne Mattes: Can you clarify for us? Are you talking about once you make it to the EDR?

Lisa Moser: I'm just talking about the initial spreadsheet, the first column asks for an active appeal number and we don't have that. I have it on the level two and I have it on ALJ level, but not on the level one.

Cyndy Ginsburg: We don't ask you for appeal numbers, we generate the spreadsheet. And then if there's something on the spreadsheet you don't agree with, you do an EDR.

Lisa Moser: Okay.

Suzanne Mattes: You don't actually have to provide any of that information upfront this time.

Lisa Moser: Okay.

Suzanne Mattes: If you participated in one of the other hospital appeal settlement initiatives, I know in 2014, we asked the appellants to generate spreadsheets themselves. This time we're doing it for you. We're pulling data to try to save you some of that trouble and then all you have to do is validate it for us.

Lisa Moser: Okay. All right. I was trying to be proactive so that this won't really come out until after we submit the Interest basically.

Suzanne Mattes: Right. Exactly.

Lisa Moser: Okay. Got you. Thank you.

Operator: Your next question comes from the line of Linda Martin.

Linda Martin: Hi Linda Martin, SSM Health. I had a question concerning the email submission. You had mentioned that you triage by the subject line. Could you clarify again what the subject line needs to state for the Expression of Interest submission?

Suzanne Mattes: We would just ask that you include that it's an EOI for the IRF Appeals Settlement process and the appellant name.

Linda Martin: Okay. Thank you.

Operator: Your next question comes from the line of Lynn Matheny.

Lynn Matheny: Hello! This is Lynn Metheny at Baptist Health Medical Center in Little Rock, Arkansas. And my question has to deal with we have 2 rehabs, we have one in North Little Rock and one in Little Rock. Our North Little Rock we did receive all of our information. We agree with all the records that were on the spreadsheet.

So, I am going to have the agreement signed and then I need to send you the eligible appeals where the appellant must mark the yellow columns and so I will put yes on the appeals are down coded and I enter that yes and I send those 2 back to you, correct, the agreement and the eligible appeals?

Suzanne Mattes: If you -- so just to clarify, there are some appeals that you believe that we need to modify in some way, as in they're eligible for 100% percent or –

Lynn Matheny: No. I mean for our North Little Rock facility, we're in agreement with the list that was sent to us.

Suzanne Mattes: Okay. So, if you're in agreement with the list that was sent to you all you have to do is return it to us as is and sign the agreement, we do the rest.

Lynn Matheny: Okay. I was just wondering if on the eligible appeals in red it says appellant must complete the yellow columns below. And if the answer is no, we leave it blank, but if it's yes then we put a Y in there. And so, I just wanted to make sure that I had that filled out completely before I sent that back.

Suzanne Mattes: Got you. We're going to double check on that if you don't mind shooting that to me in the email box, MedicareAppealsSettlement@cms.hhs.gov, we'll take a look at it for you.

Lynn Matheny: Okay and then our Little Rock facility what we reviewed the list and we found 8 claims that we still need to be on the list. So, for that one I just send you the EDR. And we did download the EDR list and it asks for the ALJ appeal number, which we won't have, the DAB – the docket number we won't have. And so, the DC and claim number, date of admission in the comment is what we add to that and send with it.

Suzanne Mattes: That's correct. So, what we're asking you to do is if the spreadsheet that we sent to you, you know, it's prompting you to put these on the EDR, obviously you're talking about ones that were not included in the list that you believe should be included. Put as much information as you can, and we'll do the best we can with it.

If you're including ones that are on the list and shouldn't be or that you would like us to review for 100%, put the data exactly as it is from the spreadsheet that you received from us. Does that make sense?

Lynn Matheny: That does make sense. But now so all I need to send to you then in an email is the EDR.

Suzanne Mattes: Correct.

Lynn Matheny: So, the eligible appeals in the agreement don't send that until we figure out what to do with these 8 claims.

Suzanne Mattes: You got it.

Lynn Matheny: Great. Thank you.

Operator: Your next question comes from the line of Greg Groninger.

Greg Groninger: Hi! This is Greg Groninger from HCA. I have a question about the Eligibility Determination Request. What if you have a claim that was denied for both Intensity of Therapy and group therapy, and also is there a denial code or denial reason that will be given to us by the MAC or the QIC that we could search for these Intensity of Therapy and group therapy distinction? Thank you.

Suzanne Mattes: For our purposes, for the EDR, you just have to mark it on the EDR as eligible for 100% payment and we'll do the rest. You don't necessarily have to identify that is or potentially is eligible under both of the criteria that would result in a 100% net payment. With respect to the question you asked about the code, there isn't any particular response that the MAC will be providing that indicates why or whether the denial reason was adequate for these purposes. The MAC will be providing the ultimate conclusion as to whether in its review it believes that it meets the criteria or doesn't meet the criteria, that's all we would be providing.

Hazeline Roulac: Thanks for your question.

Operator: Your next question comes from the line of Peter Thomas.

Peter Thomas: Hi! This is Peter Thomas with Powers Law Firm. First, I wanted to thank you for hosting this call and providing this additional information as well as your efforts individually to follow up with some of our questions on behalf of IRF clients.

One example is the question about the ALJs, whether they had been instructed to postpone hearings when requested by providers. And I know now that the answer to that is no, they haven't been instructed. But, of course, it makes sense that they would do that if they want to decrease the backlog to the maximum extent possible.

My question involves the 180 days for payment. First off, I wanted to clarify and just make sure that interest is paid by CMS if that payment has not been received by the provider after 180 days, number one, and number two, what is the realistic time frame or estimate. I know 180 days is completely permissible. But do you have a better sense for when those payments will likely be made better than just kind of the outside estimate of 180 days?

Hazeline Roulac: Bear with us just a moment.

Suzanne Mattes: Hi, Peter! It's nice to hear from you. Thanks for your question. The settlement agreement language actually specifically references the payment of interest. So, we would just ask that you take a look at that and see whether that answers your question and I can loop back with you on that as well.

With respect to the 180 days for payment, also I'll say this, it depends on the MAC's workload. Generally, we're able to make payment well before the 180-day time frame. I think we've seen payments made as quickly as within 60 days, maybe even less than that depending on the MAC's workload. I think, unfortunately, that's probably the best that I can offer as a general response. But if you have any other specific questions about a specific case or anything like that, we're happy to look into it for you.

Peter Thomas: Great. And if my line is open still, it did say in the settlement agreement that 180 days, after 180 days interest would be paid, just wasn't in today's presentation, I just wanted to clarify that and confirm it.

Suzanne Mattes: Got you, Peter. Thank you. Yeah, we appreciate you drawing our attention to that. Thanks so much.

Peter Thomas: Very good. Thank you.

Operator: Your next question comes from the line of Jodi Loduca.

Jodi Loduca: Hello! This is Jodi Loduca from Froedtert Health. I have a question similar to a previous caller on columns L through O in the eligible appeal spreadsheet. I'm confused on whether I need to enter anything in those boxes if we agree with everything currently in the spreadsheet. So, for instance they have Medicaid state

agency participation, appeal of DRG down code, post payment claim, and if the claim is part of an overpayment extrapolation. So, we're just not sure to leave everything blank or how to proceed with that.

Suzanne Mattes: Thank you for pointing that out to us. Again, I'm sure I sound like a broken record. If you would please send it to the Medicare appeals settlement mailbox, we can take a look at it more specifically. We suspect that we know what's going on, but we want to confirm before we respond to you. Once we take a look, we should be able to get back to you fairly quickly. There's no expectation that you fill that out, but this column shouldn't be present on your spreadsheets at all.

Jodi Loduca: Okay. That would be great. And who will I receive the reply email from, what address will that be, will that be the same?

Suzanne Mattes: Probably not, you will probably receive it from one of my folks here, either Cyndy Ginsberg or Nicholas or one of our other staff people here in this office that'll actually look into it for you.

Jodi Loduca: Okay. Thank you.

Operator: As a reminder, to ask a question press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Your next question comes from the line of Jane Mansusky.

Jane Mansusky: Yes. Thank you. This is my second question. I'm sorry for taking up the time. We had several claims that were denied for a — solely therapy and the signing of the physician order. And as we know Medicare has since then come out and said signing the physician order is not a regulation for inpatient rehab due to avoiding duplication. So, if a claim was solely denied for those two reasons, do we put it on the EDR and check a 100% bracket?

Suzanne Mattes: I think out of the abundance of caution the way I'm going to answer that is feel free to submit the EDR. The MAC will take a look at the documentation that we have available and make a decision based on that information. But I think it's worth it to you to submit the EDR.

Jane Mansusky: Perfect. Thanks so much.

Operator: As a reminder, to ask a question, please press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. One moment for your next question. Your next question comes from the line of Dan Dagel.

Dan Dagel: Hi! I wanted to know why August 31, 2018, was chosen as a cutoff date and whether or not that date will be revisited.

Suzanne Mattes: At this time, that date will not be revisited. That date was selected by us for a variety of reasons. But at this point, we aren't able to necessarily discuss them specifically. That’s the date that we chose.

Dan Dagel: Thank you.

Operator: Your next question comes from the line of Greg Groninger.

Greg Groninger: Hi! This is Greg Groninger from HCA. In reference to the published FAQ's on the CMS website regarding interest, it's my understanding that we will actually, in addition to 69% recouped or – be repaid interest that was recouped, but we will not be repaid interest we would have earned had we won at ALJ level, is that correct?

Suzanne Mattes: Bear with us one second, we're double checking. I want to say that we believe that the answer to your question is yes, but I would prefer that you send it to us in the mailbox and we can provide you with more specific response. And if we need to clarify the FAQ that's listed on our website, we'll make sure we do that.

Greg Groninger: Thank you and thanks for the call.

Hazeline Roulac: You're welcome.

Operator: And there are no further questions at this time. We'll turn the call back over to Hazeline.

Additional Information

Hazeline Roulac: Thank you, Dorothy. If we did not get to your question, you can email it to the address listed on the slide 15. We hope you will take a few moments to evaluate your experience with today's call. Please see slide 16 for more information about evaluating the call. An audio recording and transcript will be available in approximately two weeks at go.cms.gov/npc.

My name is Hazeline Roulac. I want to thank our subject matter experts, and also thank you for participating in today's Medicare Learning Network event on IRF Appeal Settlement Initiative. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.