FINAL FOR RELEASE: JUNE 2019
WEB TEXT

Web Text Summary: June 13, 2019
CMS announces voluntary Inpatient Rehabilitation Facility (IRF) appeals settlement option

As part of its commitment to reduce outstanding appeals and burdensome administrative paperwork, CMS will implement a new voluntary appeals settlement option for certain Inpatient Rehabilitation Facilities (IRF). Beginning June 17, 2019 the agency will work with IRF sites to settle appeals pending at the Medicare Administrative Contractor (MAC), the Qualified Independent Contractor (QIC), the Office of Medicare Hearings and Appeals (OMHA) and Medicare Appeals Council (*Council*) levels of review. CMS will include situations where appeal rights for IRF-related claims have not yet been exhausted at the MAC, QIC, OMHA and/or Council level. Specific details on the process can be found at https://go.cms.gov/IRF.

Web Text Details: June 17, 2019 -- CMS announces voluntary appeals settlement options for Inpatient Rehabilitation Facilities

Beginning June 17, 2019, CMS will accept Expressions of Interest (EOIs) for a settlement option targeted towards certain Inpatient Rehabilitation Facility (IRF) appeals pending at the Medicare Administrative Contractor (MAC), the Qualified Independent Contractor (QIC), the Office of Medicare Hearings and Appeals (OMHA) and/or Medicare Appeals Council (*Council*) levels of review. CMS expects to include situations where appeal rights for IRF-related claims have not yet been exhausted at the QIC, OMHA and/or Council level.

Specifically, IRF appellants that filed appeals at the MAC for redetermination no later than August 31, 2018, that are currently pending or are eligible for further appeal at the MAC, QIC, OMHA, or Council, will have the opportunity 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 special criteria below:

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

- CMS will pay 100% of the net payable amount for all IRF appeals in which the claim was denied *solely* because justification for group therapy was not documented in the medical record.

Although the appeal must have been filed no later than August 31, 2018, CMS relies on the date the settlement agreement is signed to determine whether appeals are ultimately included in the settlement. Appeals must be pending at the MAC, QIC, OMHA, and/or Council, as of the date the settlement agreement is signed. If they are no longer pending, but are eligible for further appeal have not exhausted timely filing, CMS will include those, as well.

Eligibility: 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 level of appeal, as of the date of CMS's signature on the Settlement agreement;
- 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 participated in the reconsideration;
- It does not involve items, services, drugs, or biologicals billed under unlisted, unspecified, unclassified, or miscellaneous healthcare codes (e.g., CPT Code 38999 Unlisted procedure, hemic or lymphatic system; K0108 Wheelchair component or accessory, not otherwise specified);
- It does not arise from a MAC, QIC, ALJ, or Council dismissal order;
- It includes Part A IRF claims only; and

Ineligible appellants are:

- Medicare beneficiaries, Medicare Advantage plan enrollees, their family members, or estates.
- State Medicaid Agencies.
- Medicare Advantage Organizations (Medicare Part C).
- IRFs that filed for bankruptcy or expect to file for bankruptcy.

- Certain appellants that are or were involved in False Claims Act litigation or investigations, or those that have other program integrity concerns, including pending civil, criminal, or administrative investigations.

If an appellant is approved for participation in this process, the resulting settlement will apply to all eligible appeals from that appellant. As part of the settlement agreement, the appellant cannot choose to settle some appeals and continue to appeal others.

Settlement Process

The settlement process is initiated by the appellant submitting its EOI to CMS at MedicareAppealsSettlement@cms.hhs.gov.

If the appellant is approved for participation, CMS will send the appellant (1) a list of potentially eligible appeals and the associated claims for the appellant's review; and (2) an Administrative Settlement Agreement. The appellant will validate the spreadsheet, sign and return the Settlement Agreement to CMS. CMS will counter sign and send a copy of the fully executed Settlement Agreement to the appellant.

- If, during validation, the appellant discovers discrepancies on the eligible appeals list, the appellant must notify CMS by submitting an Eligibility Determination Request (EDR) to CMS at MedicareAppealsSettement@cms.hhs.gov within 15 calendar days of receiving the package containing the list of potentially eligible appeals and the Administrative Agreement.
- The appellant must also submit an EDR request if the appellant believes that appeals on the spreadsheet meet either of the criteria in the "Intensity of Therapy Appeals" description, above. EDR instructions are included in the Downloads section below.

CMS and the appellant have 30 days to resolve any discrepancies and validate whether any of the appellant's appeals are eligible for payment at 100% under the terms of the settlement. Once any discrepancies are resolved, the appellant will sign and return the Administrative Agreement to CMS. CMS will counter sign and send a copy of the fully executed Agreement to the appellant.

At any time prior to the appellant signing the agreement, the appellant may withdraw from the settlement process and will retain their full appeal rights. All active proceedings on all eligible pending appeals submitted in this settlement process will be stayed once the appellant signs the Administrative Agreement. Please see the process document in the Downloads section below for additional details.

Expression of Interest Period

Please submit Expressions of Interest between June 17, 2019 and September 17, 2019. To request participation in the process, all IRF appellants must complete the EOI and submit it to MedicareAppealsSettlement@cms.hhs.gov.

Additional Information

See the Downloads section below for Frequently Asked Questions or email your questions to MedicareSettlementFAQs@cms.hhs.gov. CMS may post and periodically update the Frequently Asked Questions about this IRF Appeals settlement process.