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MEMORANDUM

TO: Health Care Clients and Friends

FROM: Powers, Pyles, Sutter & Verville, PC

DATE: June 5, 2008

RE: CMS Adopts Changes to PRRB Appeal Procedures

On May 23, 2008, the Centers for Medicare and Medicaid Services (CMS) published a final rule that substantially changes the procedures for appealing a Medicare cost report determination included in a notice of program reimbursement (NPR) before the Provider Reimbursement Review Board (PRRB).[1] The final rule follows a proposed rule that CMS published on June 25, 2004. Many of these revised requirements will require providers to alter their internal practices and, in some respects, make the appeal process more difficult for providers. Most provisions of the final rule will become effective on August 21, 2008.

The following is a brief summary of some of the significant changes included with the new regulations. The final rule is available on the Internet at http://edocket.access.gpo.gov/2008/pdf/E8-11227.pdf.

Self-Disallowance Policy and Procedure

The Medicare statute states that a provider may obtain a PRRB hearing if (1) the provider is "dissatisfied" with its Medicare reimbursement for a cost reporting period; (2) the amount in controversy is at least $10,000 for an individual hospital (or at least $50,000 for a group appeal);

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[1] 73 Fed. Reg. 30190 (May 23, 2008).

and (3) the provider files a timely request for a hearing to the PRRB. The new regulations specifically address how providers may satisfy the first requirement.

Under the revised rules, a provider has the right to a hearing before the PRRB with regard to specific items claimed for a cost reporting period if the provider preserves its right to claim "dissatisfaction" with the amount of Medicare payment for the specific item or items at issue by either (1) claiming the cost on its cost report; or (2) by filing a cost report under protest by "self-disallowing" a specific item or items. A provider should "self-disallow" costs for which it seeks reimbursement, but are (in the provider's opinion) contrary to Medicare policy and rules. If a matter is omitted from a provider's cost report, the provider will not be considered to be "dissatisfied" with a fiscal intermediary's decision, and the PRRB cannot assert jurisdiction over that matter.

Under the new rules, when "self-disallowing" a cost, a provider must follow the procedures in the Provider Reimbursement Manual for claiming an item under protest.[2] These procedures require a provider to identify the disputed item and amount for each issue in footnotes to the cost report settlement worksheet. The reimbursement effect of the self-disallowed item must be estimated using a "reasonable methodology." While CMS encourages providers to cite to the legal authority believed to prevent Medicare payments for the self-disallowed item, providers are not required to do so.

This provision is effective with cost reporting periods ending on or after December 31, 2008. CMS stated that it is delaying the effective date of this new requirement so that providers will have additional time to evaluate whether they wish to include self-disallowed items in their filed cost reports. Finally, CMS may require the fiscal intermediary to audit the item for which a provider receives a favorable decision from the PRRB, the CMS Administrator, or a court.

New Limitation on the Addition of Issues to PRRB Appeals

Under the existing regulations, a provider may add issues to a PRRB appeal at any time prior to the hearing. In perhaps the most significant change in the new rules, however, a provider's request to add an issue or issues to its submitted hearing request must be received by the PRRB within 240 days of the provider's receipt of the NPR.[3] This timeframe may not be waived even if both the provider and intermediary agree to do so.

For appeals that are pending before the PRRB prior to August 21, 2008, which is the effective date of the final rule, a provider that wants to add an issue or issues to its filed appeal must do so by the later of either (1) October 20, 2008; or (2) 240 days from the date of receipt of its NPR.

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[2] The self-disallowance procedures can be found at Provider Reimbursement Manual, Part II, Section 115 (CMS Pub. 15-2).

[3] The 240-day time limit was computed by adding a 60-day period that CMS has allowed for adding issues to the applicable 180-day period for filing the original hearing request.

Contents of Hearing Requests

The new regulations establish specific requirements for the contents of a provider's request for a hearing:

- A demonstration that a provider satisfies the jurisdictional requirements for a hearing.

- An explanation of the provider's dissatisfaction for each item in dispute. The appeal letter must include the reasons that the provider believes Medicare payment is incorrect, and how and why Medicare payment must be determined differently. If a provider lacks enough information to determine the full basis for its dissatisfaction, the provider should note that in its request for a hearing.

- A copy of each intermediary or CMS determination at issue in the appeal, and any other documentary evidence a provider considers necessary to meet the requirements to obtain a Board hearing.

- For a provider under common ownership or control, the name and address of its parent corporation and a statement that, to the best of its knowledge, no other related provider has a pending appeal on the same issues for the same fiscal year or that such an appeal exists, with identifying information.

The PRRB may dismiss a non-compliant hearing request with prejudice or take alternative action as it deems appropriate.

Scope of the PRRB's Authority

The Medicare statute states that the Board has the statutory authority to affirm, modify, or reverse an intermediary's findings on specific matters regardless of whether the intermediary considered those matters in making its determination. In the final rule, CMS clarified that the PRRB may consider or decide a specific matter at issue only if the PRRB has jurisdiction over the issue and the issue was timely raised in the provider's hearing request.

Other Regulatory Changes to the PRRB Appeals Process

- **Good Cause for Extending Filing Deadline**: The time limit for submitting a hearing request can be extended for "good cause" only in cases where a provider can establish that due to "extraordinary circumstances," it could not file a hearing request within the 180-day period. Regardless, the request must be submitted within a reasonable length of time, and in no event more than three years following the date the NPR was issued.

- **Amount in Controversy**: The amount in controversy is determined based only on those particular adjustments that the provider has challenged within the same cost year. Additionally, if a provider requests a hearing before an intermediary for an amount that is subsequently determined to be at least $10,000, the appeal will be transferred to the PRRB.

- **<u>Quorum Requirements</u>**: Only one PRRB member is required for a quorum at hearing, and a quorum of at least three PRRB members is required to issue a final PRRB hearing decision.

- **<u>Discovery and Subpoenas</u>**: The new rules amend the procedures for discovery and for requesting PRRB subpoenas, including modified time limits.

- **<u>Failure to Abide by PRRB Rules</u>**: If a provider fails to meet a filing or procedural deadline or another PRRB requirement, the PRRB may dismiss the hearing request. If an intermediary fails to meet such requirements, the PRRB has the right to issue a decision based on the written record.

- **<u>CMS Instructions</u>:** If the PRRB reverses or modifies an intermediary's determination that was based on policy expressed in a CMS instruction (rather than a regulation or CMS ruling), the PRRB must explain its decision to not follow the instruction and how it gave "great weight" to such instruction.

- **<u>Reopening Procedures</u>**: CMS clarified and revised certain matters regarding reopening procedures. Specifically, the new rules state that a change of a legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction is not a basis for reopening a determination, and that a decision to reopen a determination is not subject to further administrative or judicial review.

- **<u>Group Appeals</u>**: CMS adopted amended rules for group appeal procedures. Among other changes, providers may now appeal more than one cost reporting period with respect to the same issue to meet the $50,000 amount in controversy jurisdictional requirement, and CMS modified procedures for determining whether a group is fully formed.

Next Steps For Providers

- Prior to October 20, 2008, providers should review all pending appeals to determine whether there are additional issues that should be added. (Again, for appeals filed before August 21, 2008, providers may add issues until the later of October 20, 2008 or 240 days from receipt of the NPR.)

- Providers should implement an internal appeal review mechanism to ensure prompt and complete review of potential appeal issues in future intermediary NPR determinations.

- Providers should review their cost report filing process to ensure that appeal rights are preserved by either claiming the cost item or using the protest item procedure.

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If you have any questions, please call Mary Susan Philp at (202) 872-6735, Barbara Straub Williams at (202) 872-6733, or the attorney with whom you usually work.