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CMS Issues Final Rule on PRRB Appeals

An overview of changes and practical tips

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On May 23, 2008, the Centers for Medicare and Medicaid Services (CMS) issued a final rule revising the regulations governing Provider Reimbursement Review Board (PRRB) appeals.¹ It is similar in many respects to the proposed rule published in 2004.²

The final rule is effective August 21, 2008, with three exceptions discussed below.³ The PRRB plans to issue new instructions before the effective date of the final rule.⁴ If the new PRRB instructions are not issued by that date, the revised regulations will supersede existing PRRB instructions to the extent that they conflict.

The final rule makes significant changes to the current regulations. Gone are the days a provider could mail its appeal to the PRRB on the 180th day after receiving its notice of program reimbursement (NPR) and add issues up until the day of the hearing. Providers now will be required to plan ahead: listing self-disallowed costs as protested items on cost reports, including more information in hearing requests, and filing appeals so that the PRRB receives them by the 180th day.

Among the changes under the final rule include the method in calculating time period and deadlines,

extension of time for filing an appeal, adding issues to an individual appeal, self-disallowed costs, content of request for hearing, group appeals, amount in controversy, presentation of papers and discovery, hearings, sanctions, remands, and reopenings. Following is an overview of these changes, as well as related practical tips.

Calculating Time Periods and Deadlines: §§ 405.1835(a), 405.1801(a)

The final rule changes the method for counting the start and the end of the 180-day period in which a "provider" may file an appeal.⁵ Under the final rule, time runs from the "Date of Receipt"⁶ for both the start and the end of the 180-day time period.

Receipt is presumed to be five days after the postmark date for the final determination, unless the provider shows evidence of later receipt. The end date will be the date the PRRB (or other reviewing entity) receives the appeal. If a provider uses a nationally recognized next-day courier service (such as Express Mail, Federal Express, UPS, or DHL), receipt will be presumed to be the date of delivery on the courier receipt. If a provider uses any other method of delivery, the date of receipt will be the date the PRRB or other reviewing entity stamps "received."

Practical tips: Providers should establish procedures to:

1. keep all postmarked envelopes containing final determinations, and

2. routinely date stamp them with the receipt date.
3. Providers also should use a nationally recognized next-day courier service to send any documents to the PRRB with time limits running from the date of receipt (including each request for hearing and request to add issues).

Extension of Time for Filing Appeals: § 405.1836

It always has been difficult for a provider to obtain an extension of time to file an appeal. The final rule clarifies the limited grounds for obtaining an extension for “good cause,” provides that denials are subject to administrator review and reopening, and bars judicial review.

“Good cause” is limited to extraordinary circumstances beyond a provider’s control, such as a natural catastrophe, fire, or strike. It does not include a change in law, regulations, CMS rulings, or instructions.

Any request for an extension of time must be filed within a reasonable time after the time to appeal has expired, but no later than three years after the date of the final determination. Any provider that would otherwise be prejudiced by the three-year time period will have until 60 days after August 21, 2008, to file a request for a good cause extension.

Practical tip: Since such “good cause” extensions are rarely granted (given the limited grounds for “good cause”), providers should make every effort to file appeals timely.

Adding Issues to Individual Appeals: § 405.1835(c)

The final rule severely limits when a provider may add an issue to a pending appeal. Under the current rule, a provider can add an issue any time up to the date of hearing without PRRB permission, as long as the fiscal intermediary is not prejudiced by the late addition of the issue.

The current rule has allowed providers to add issues many years after filing appeals, based on learning the outcome of other appeals. Under the final rule, a provider:

1. must request board permission to add an issue, and
2. may do so only until 60 days after the 180-day time to appeal has run (*i.e.*, within 240 days after receiving the NPR).

This change essentially limits providers to adding issues they mistakenly omitted when filing the appeal. For appeals pending before August 21, 2008 (the general effective date of the final rule), the new time limit on adding issues is effective the later of either 60 days after the expiration of the 180-day time to appeal or October 20, 2008.⁷

Practical tips: Providers should review all pending appeals and add any missing issues before October 20, 2008. For any new appeal, providers should try to include all issues in the initial request for hearing. Providers also should calendar a review of the issues within 240 days of the NPR in order to file a request to add any missing issues before the request is time barred.

Self-Disallowed Costs: § 405.1835(a)(1)(ii)

In a major departure from the current rules, the final rule bars a provider from appealing a self-disallowed cost⁸ unless it has listed the item on its cost report as a protested item. The procedures for filing a cost report under protest are in the Provider Reimbursement Manual, Part II (CMS Pub. 15-2) at Section 115. To avoid a flood of amendments to recently filed cost reports for fiscal year (FY) 2007, this portion of the final rule is effective for cost reporting periods ending on or after December 31, 2008.

Current PRRB regulations do not address self-disallowed costs. Instead, multiple court cases have addressed when a provider may claim a self-disallowed cost.⁹ Several comments on this provision of the proposed rule asserted that it is inconsistent with the U.S. Supreme Court’s decision in *Bethesda* and violates the Social Security Act provisions on PRRB jurisdiction.¹⁰ It remains to be seen whether providers will challenge the new rule on this basis.

If a provider prevails on an issue involving a self-disallowed cost, the final rule allows CMS to require a fiscal intermediary to audit such cost before issuing a revised NPR.¹¹ In such cases, the board is not required to retain jurisdiction of the case. If the provider disagrees with the results of the audit, it must file another appeal.

Practical tip: Any provider wishing to appeal a self-disallowed cost should list it on its cost report as a protested item.

Content of Request for Hearing: § 405.1835(b)

The final rule requires providers to include more information in the Request for Hearing and permits the PRRB to dismiss the appeal if the request

is incomplete. Among the items now required is a statement:

1. that no related provider has a pending PRRB appeal on any of the same issues for the same period or, if one does,
2. listing the provider's name, number, and the case number.

The board now may require a related organization (including a controlling parent) to be a party to the appeal.¹² These provisions are designed to enable the PRRB to administer its new rules on mandatory group appeals.

Practical tips: All providers should prepare appeals earlier to assure they contain all required information. Related providers should closely coordinate all PRRB appeals.

Group Appeals: § 405.1837

The final rule on group appeals contains significant changes from both the current and the proposed rule. Group appeals aggregate providers who challenge a single issue involving a common question of fact or law, where each provider meets the jurisdictional criteria for filing an individual appeal (except for the amount in controversy) and the amount in controversy totals \$50,000.

There are two types of group appeals: mandatory and optional. A group appeal is "mandatory" if it involves at least two providers that are under common ownership or control.¹³ A provider may not appeal any issue in an individual appeal¹⁴ for a given fiscal year that is covered by the group appeal. A group appeal is "optional" if it involves unrelated providers. Group appeals provide an efficient means of resolving **Group** disputes common to multiple providers, and bind all providers who are parties to the appeal.

Mandatory Group Appeals

All providers under common ownership or control are required to form a group regarding each common issue of fact or law occurring in the same calendar year. If such a provider mistakenly files an issue as part of an individual appeal that should have been filed in a group appeal, the PRRB may transfer the issue to a group appeal or form a group into which the issue may be transferred.

Since providers may receive NPRs at different times, a single provider may now form a mandatory group while waiting for other related providers to receive their NPR. Once the board has determined

that a mandatory group is fully formed, a related provider may not be added to the group for a calendar year covered by the group appeal unless the board modifies its order finding the group to be fully formed.¹⁵

Optional Group Appeals

A provider no longer has a right to have an issue transferred from an individual appeal to an optional group appeal. Instead, it must request permission from the PRRB to do so. Once a group is "fully formed," providers may be added to the group if the board agrees.

All Group Appeals

Providers may appeal more than one cost reporting period in order to meet the \$50,000 jurisdictional amount or in the board's discretion. Different providers may appeal different cost reporting periods.

Group appeals still are limited to a single issue. The questions are: what is a single issue, and what happens if the group appeal includes more than one issue? In the preamble to the final rule, CMS recognizes that a single "issue" may include more than one line on a cost report and may not be a "cost."¹⁶ Where the board finds that a group appeal includes more than one issue, the board will assign a new group case number for each additional issue.¹⁷

The PRRB will decide whether a group meets the \$50,000 amount in controversy once the group is "fully formed." The final rule sets out revised procedures for determining when a group is "fully formed." In this connection, the rules no longer require group appeals to be "closed" within one year. Moreover, once a group is fully formed, the board has discretion to allow additional providers to be added.

Once a provider joins a group appeal, it may not transfer an issue to an individual appeal unless the group fails to meet jurisdictional requirements.¹⁸ In such a case, the PRRB will create an individual appeal for the provider if it meets the jurisdictional requirements for an individual appeal (including \$10,000 in controversy).

The board will deem the date of receipt of the provider's request to form or join a group to be the date of receipt for purposes of filing an individual appeal and adding issues to that appeal. Since the provider will have appealed only one issue in joining the group, the provider may add other issues to its individual appeal, provided it does so within 180 days plus 60 days from the deemed date of receipt.

The final rule prescribes the contents of the request for hearing for group appeals, and the preamble clarifies what documents must be attached for each provider. Instead of having to attach the entire NPR and audit adjustment report for each provider in the group, it is now sufficient to attach the first page of the NPR and the audit adjustment(s) at issue.¹⁹

Amount in Controversy: § 405.1839

The final rule clarifies that if the hearing request for an individual appeal meets the \$10,000 amount in controversy, the subsequent transfer, dropping, or settlement of an issue will not deprive the PRRB of jurisdiction. For group appeals, providers may add multiple years if needed to meet the jurisdictional amount of \$50,000, and different providers may appeal different years. The board will judge whether the amount in controversy meets the \$50,000 threshold once the group is fully formed.

Position Papers and Discovery: §§ 405.1853, 405.1857

The final rule modifies the requirements for position papers. Documents regarding jurisdiction must be attached. Documents supporting the merits now may be submitted later, in a timeframe to be decided by the board.

The final rule also specifies timeframes for discovery and subpoena requests, modifying those in the 2004 proposed rule. Both timeframes are based on the initial hearing date. Discovery requests must be served on a party or nonparty at least 120 days before that date. Requests to issue a subpoena must be received by the PRRB within the following timeframes:

1. if for discovery, 120 days before the initial hearing date, and
2. if for an oral hearing, 45 days before that date.

The PRRB may not subpoena any person from CMS.

Hearings: § 405.1845

The final rule allows the PRRB to hold an oral hearing with only one board member presiding, without consent of the parties. Issuing a hearing decision continues to require a quorum of three board members, one of whom must be a representative of providers.

The provider may request a hearing on the written record with the consent of the fiscal intermediary and the board. The final rule specifies what documents are part of the “record” that the board may consider.²⁰

Sanctions: § 405.1868

Where a fiscal intermediary fails to meet a deadline, the final rule allows the PRRB to decide a case on the written record submitted to that point. While this does not entirely level the playing field (since the board may dismiss a provider’s appeal for failure to meet a deadline), it does provide a sanction with some teeth.

Remand: §§ 405.1845(h), 405.1871(b)(5)

The final rule specifies several circumstances where the board may or must order a remand. Generally, the rules require a remand where the fiscal intermediary has not had an opportunity to review the merits of a provider’s claim or to audit a cost. Thus, where the board agrees with a provider’s claim on self-disallowed costs, the board will order a remand so that the fiscal intermediary may audit the costs.

Also, where the board reverses a fiscal intermediary’s denial that was based on procedural grounds (such as failure to meet time limits or provide adequate documentation), the board must remand to the fiscal intermediary for a determination on the merits. The board order remanding the case is not appealable. The board does not retain jurisdiction of the case. If the provider is dissatisfied with the fiscal intermediary’s determination after remand, it may appeal that new determination.

Reopenings: § 405.1885

The final rule clarifies the calculation of time limits for a reopening. While the fiscal intermediary (or CMS, if it issued the determination) may reopen a final determination by *mailing* a notice of reopening within three years of the date of such determination, a provider may request a reopening only if its request is *received* within three years of the same date.

As with a request for hearing, if a provider uses a nationally recognized next-day courier service, the date of receipt will be deemed to be the date shown on the delivery slip. In the case of a reopening initiated by a provider, if the fiscal intermediary decides to reopen, it must send a notice of reopening, which may be sent after the three-year period.

In a welcome departure from current rules, the final rule allows all parties to submit additional evidence supporting the reopening within a reasonable period of time after the notice of reopening. This is significant, since some fiscal intermediaries currently require providers to submit all documents before the three-year period expires. Since a fiscal intermediary’s decision whether to reopen still is discretionary, however, providers should

submit enough documentation with their initial request to convince the fiscal intermediary to issue a notice of reopening.

The final rule also “clarifies” or revises other issues relating to reopenings. A change in legal interpretation or policy by CMS is not a basis for a reopening. A fiscal intermediary may reopen an issue that is part of a pending PRRB appeal. Also, any matter considered in a reopening but not later revised cannot be appealed.

Practical tips: If the fiscal intermediary issues a notice of reopening on an issue already in a pending PRRB appeal, the provider should not drop the issue from the appeal until it is satisfied with the results of the reopening. Moreover, if a provider wishes to preserve its right to appeal an issue to the PRRB and ultimately to a court, it should include the issue in a request for hearing filed with the PRRB (within 180 days of receipt of the final determination) or timely add it to the appeal (within an additional 60 days), since there is no assurance that an issue presented to the fiscal intermediary in a reopening will result in a revised determination that is appealable. ■

Notes

1. 73 *Federal Register* 30190 (May 23, 2008). The Final Rule amends the regulations at 42 C.F.R. § 405.1801 *et seq.*, which govern fiscal intermediary hearings, PRRB appeals, administrator review, and reopenings.
2. 69 *Federal Register* 35716 (June 25, 2004). The preamble to the final rule lists the changes from the proposed rule at 73 *Federal Register* 30237–30240.
3. The exceptions apply to the effective date for the revised regulations on: seeking a good cause exception to late filing, adding issues, and claiming self-disallowed costs.
4. 73 *Federal Register* at 30209 and discussions with PRRB staff. The PRRB had issued draft revised instructions in early 2005 similar to the CMS proposed rule published in 2004. The PRRB will be revising these draft instructions to be consistent with the final rule.
5. A “provider” is defined to mean a hospital, critical access hospital, skilled nursing facility, home health agency, hospice, renal dialysis facility, comprehensive outpatient rehabilitation facility, federally qualified health center, and rural health center. 42 C.F.R. § 405.1801(b)(1).
6. 42 C.F.R. § 405.1801(a).
7. 73 *Federal Register* at 30236.
8. A “self-disallowed cost” is one the provider cannot claim (without running the risk of making a false claim) because claiming the cost is not, or may not be, in accordance with Medicare policy.
9. *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988); *see also Little Company of Mary Hospital and Health Centers v. Shalala*, 24 F.3d 984 (7th Cir. 1994); *Maine General Medical Center v. Shalala*, 205 F.3d 493 (1st Cir. 2000); *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007).
10. Social Security Act § 1878(a)(1)(A)(i) requires that a provider be dissatisfied with a final determination as to the total amount of program reimbursement.
11. 42 C.F.R. § 405.1803(d)(3).
12. 42 C.F.R. § 405.1843(a).
13. Mandatory group appeals also are known as Common Issue Related Party (CIRP) appeals.
14. The final rule uses the phrase “individual appeal” and “single appeal” interchangeably.
15. 73 *Federal Register* at 30212.
16. 73 *Federal Register* at 30213.
17. 42 C.F.R. § 405.1837(f)(2)(ii).
18. 42 C.F.R. § 405.1837(e)(5).
19. 73 *Federal Register* at 30212.
20. 42 C.F.R. § 405.1865.

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