PUBLICATION

Changes Proposed to PRRB Dissatisfaction Requirement [Ober|Kaler]

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On May 15, 2014, CMS published in the Federal Register its FY 2015 IPPS Proposed Rule [PDF], which included changes and updates to its Medicare IPPS policies. 79 Fed. Reg. 27978-28384. One change that CMS proposes is to amend the Provider Reimbursement Review Board (PRRB or Board) appeals regulations, eliminating the provider dissatisfaction requirement that is currently a condition for PRRB jurisdiction. 79 Fed. Reg. 28206-28217. CMS proposes similar amendments for appeals to Medicare Administrative Contractor hearing officers. 79 Fed. Reg. 28216-28217. CMS also proposes to codify in the cost reporting regulations its "existing policy," requiring each provider to include an appropriate claim for an item in the provider's cost report. 79 Fed. Reg. 28209-28212. Below is a summary of CMS's proposed changes. Comments are due by June 30, 2014.

A provider that has submitted a timely cost report may appeal to the Board the contractor's final determination, or notice of program reimbursement (NPR), for the cost period at issue. Pursuant to 42 U.S.C. §§ 1395oo(a)(1)(A), (a)(2), and (a)(3), and 42 C.F.R. §§ 405.1835(a)(1), (a)(2), and (a)(3)(i), a provider may obtain a hearing before the Board if: (1) the provider is "dissatisfied" with the final determination of the contractor or the Secretary; (2) the amount in controversy is at least $10,000; and (3) the provider files a request for a hearing to the Board within 180 days of notice of the final determination of the contractor or the Secretary. If the contractor has not issued a timely NPR, the provider may still appeal if it meets the requirements under 42 U.S.C. §§ 1395oo(a)(1)(B), (a)(2), and (a)(3), and 42 C.F.R. §§ 405.1835(a)(1), (a)(2), and (a)(3)(ii). These same jurisdictional requirements govern provider appeals to contractor hearing officers under 42 C.F.R. §§ 405.1811(a)(1), (a)(2), and (a)(3)(i)-(ii), except the amount in controversy is at least $1,000 but less than $10,000.

In a final rule issued in 2008 (73 Fed. Reg. 30190 (May 23, 2008)), CMS revised 42 C.F.R. § 405.1811(a)(1) and 42 C.F.R. § 405.1835(a)(1), to require, as a condition to filing an appeal, that the provider either have claimed an item in its cost report when it is seeking reimbursement that it believes to be in accordance with Medicare policy, or have included the item as a protested amount when filing its cost report if it is seeking reimbursement that it believes may not comply with Medicare policy. Now, CMS proposes to revise this requirement by moving this "must claim or protest" requirement from the appeals section of the regulations and placing it in the cost reporting section, 42 C.F.R. § 413.24(j). CMS is also revising the Board appeals regulations at Part 405, Subpart R to delete this requirement. 79 Fed. Reg. 28207-08.

Notably, CMS's proposed language for 42 C.F.R. § 413.24(j) includes a new paragraph, 42 C.F.R. § 413.24(j)(2), requiring a provider to include an estimated payment amount for each self-disallowed item in the "protested amount" line of the cost report, attach a worksheet explaining why a self-disallowance is necessary, and describe how the provider determined the estimated payment amount for each self-disallowed item. Pursuant to the proposed rule, failure to include claims for specific items in the provider's cost report will foreclose payment to the provider for the item, including payment ordered in any decision, order, or other action by a reviewing entity. 79 Fed. Reg. 28209.

CMS also proposes another paragraph, 42 C.F.R. § 413.24(j)(3), to specify the procedures for determining whether there is an appropriate cost report claim for a specific item. Under a "default rule," the contractor is to refer to the cost report that the provider originally submitted to determine whether the provider's cost report

included an appropriate claim for a specific item. Alternatively, the contractor may determine that an exception applies to the default rule. There are three exceptions permitted. First, if the provider submits an amended cost report accepted by the contractor, the contractor will determine if there is an appropriate cost report claim for the specific item by referring to the amended cost report, unless another exception applies. Second, if the contractor adjusts the provider's cost report (as originally submitted or amended) with respect to the specifically claimed item, the contractor will determine whether there is an appropriate cost report claim for the specific item by referring to the cost report as adjusted for the specific item, unless the last exception applies. Third, if the contractor reopens the initial cost report (pursuant to 42 C.F.R. § 405.1885) or revised cost report (pursuant to 42 C.F.R. § 405.1889) and adjusts the cost report as to the specific claimed item, the contractor will determine whether there is an appropriate cost report claim for the specific item by referring to the adjusted cost report for the specific item in the contractor's most recent revised contractor determination. 79 Fed. Reg. 28209-10.

In proposed paragraph 42 C.F.R. § 413.24(j)(4), CMS states that if a provider fails to claim a specific item in its cost report, the NPR will not include payment of the item. If the contractor believes the provider made an appropriate claim for a specific item, but the contractor disagrees with material aspects of the provider's claim for the item, the contractor must make appropriate adjustments to the cost report and include payment for the specific item in the NPR consistent with the adjustments. 79 Fed. Reg. 28210.

In proposed paragraph 42 C.F.R. § 413.24(j)(5), CMS states that if a provider's appeal raises questions about whether the cost report included an appropriate claim for the specific item under appeal, the reviewing entity must follow the procedures set forth in proposed regulation 42 C.F.R. § 405.1873 (if the provider originally filed the appeal with the Board) or the procedures in 42 C.F.R. § 405.1832 (if the provider originally filed the appeal with the contractor). 79 Fed. Reg. 28209. Under 42 C.F.R. § 405.1873, the Board will consider timely submitted factual evidence and legal arguments, and then prepare written specific findings of fact and conclusions of law regarding whether the provider's cost report complied with proposed 42 C.F.R. § 413.24(j).

Proposed regulation 42 C.F.R. § 405.1873(c)(1) eliminates the Board jurisdiction requirement of an appropriate cost report claim and prohibits the Board from denying jurisdiction, declining to exercise jurisdiction, imposing a sanction, or taking other actions based on its determination that the provider's cost report did not meet the proposed 42 C.F.R. § 413.24(j)'s substantive reimbursement requirement of an appropriate cost report claim for the specific item. 79 Fed. Reg. 28213.

The proposed revisions to the cost reporting regulations and provider appeals regulations would apply on a prospective-only basis and would apply to provider cost reporting periods beginning on or after October 1, 2014.

Ober|Kaler's Comments

Through this proposed regulation, CMS is once again attempting to limit providers' appeal opportunities by requiring that the providers' appeals be restricted to those issues that are fully disclosed in their cost reports, either as claimed items or as protested amounts. At first glance, some might find this position reasonable. It is not. For example, CMS often retroactively "clarifies" its positions regarding the specificity with which individual claims must be identified, described, and documented in order to be reimbursed, and it then instructs its contractors to deny payments based on these clarifications. Under CMS's proposed policy, it would seem payment denials based on such "clarifications" would be more difficult to challenge.

Those interested in commenting should submit their comments by **June 30, 2014**.

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