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CMS Adopts Final Rule Addressing Part A Appeals Before Intermediaries and the PRRB

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The Centers for Medicare and Medicaid Services (CMS) published its final rule revising procedures for Medicare Part A appeals before intermediaries and the Provider Reimbursement Review Board (PRRB) in the Federal Register on May 23, 2008. 73 Fed. Reg. 30,190 (**http://edocket.access.gpo.gov/2008/pdf/E8-11227.pdf**). With limited exceptions, the new regulations will apply to all appeals pending as of, or filed on or after, August 21, 2008. The proposed rule was first published on June 25, 2004. 69 Fed. Reg. 35,716.

The agency's stated reasons for the changes were to address updates needed since the rule was first adopted more than 30 years ago, and to reduce (or at least not add to) the backlog of appeals at the PRRB, which in essence can be interpreted to mean to restrict providers' access to appeal. Many of the new regulations are the codification of existing policy at the PRRB, but some are major changes. Some of the major provisions revising the rule that address appeals before the PRRB at 42 C.F.R. Part 405, Subpart R, are set forth below. Although the rule also address appeals before intermediaries, these provisions are not addressed in this article.

Calculating Time Periods and Deadlines (§ 405.1801(a), (d))

- Date of receipt by a party, such as a provider or intermediary, is presumed to be five days after issuance, unless established otherwise by a preponderance of the evidence.
- Date of receipt by a reviewing entity, such as the PRRB, CMS Administrator or the Attorney Advisor, is date of delivery when delivered by a nationally recognized next-day courier, or the date stamped "received" by the reviewing entity when not delivered by a nationally recognized next-day courier. Determination of date of receipt

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by a reviewing entity is final and not subject to further administrative or judicial review.

- Time begins to be counted the day after the act or event occurs which starts the clock running.
- If the deadline falls on Saturday, Sunday, legal federal holiday or a day on which the reviewing entity is unable to conduct business as usual, the deadline becomes the next day.
- CMS left it to each reviewing entity to determine whether it would accept faxed or electronically transmitted submission.

Provider Hearing Rights (§§ 405.1803(d), 405.1811, 405.1835)

- *Provider Dissatisfaction and Self-Disallowances:* In order to meet the statutory requirement that a provider be “dissatisfied" with the determination, which is requisite to PRRB jurisdiction, effective with cost reporting periods that end on or after December 31, 2008, providers will not be granted appeal rights for items that were not either expressly claimed on a cost report or self-disallowed as a protested amount on the cost report.
- *Audits of Self-Disallowed Items:* After a provider has successfully appealed a self-disallowed item, the intermediary must audit item in order to determine the proper reimbursement effect. This would require a second appeal by a provider if it disagrees with the audited amount determined by the intermediary.
- *Timeliness of Hearing Request:* A PRRB must receive the provider’s hearing request no later than 180 days after the provider received the determination being appealed.
- *Contents of Hearing Request:* Hearing requests that fail to include all the following criteria, may be dismissed with prejudice by the PRRB:
    - a demonstration that the provider has a right to hearing (i.e., has met the dissatisfaction, amount in controversy and timely filing requirements);
    - an explanation for each disputed item of why the provider believes payment is incorrect, how and why payment should be determined differently and, if self-disallowed or protested, the nature and amount of the item, as well as payment sought;
    - a copy of the determination under appeal; and
    - if the provider has any other provider entities related to it, the name and address of its parent entity and a statement that, to the best of the provider’s knowledge, no related provider has a pending PRRB hearing request on any of the same issues for the same calendar year, or a statement that such a pending appeals exists, supplying the provider name(s), number(s) and case number(s).
- *Adding Issues to Appeals:* A provider’s request to add issues to a pending appeal must be received by the PRRB no later than 60 days after the expiration of the initial 180-day filing period. For providers with appeals pending as of August 21, 2008, the deadline for adding new issues will be the later of (a) 60 days after the expiration of the 180-day appeal period or (b) October 20, 2008.

Filing Extensions (§ 405.1836)

- The PRRB may extend the 180-day filing period for good cause due to extraordinary conditions beyond a provider's control.
- No extension may be granted if the provider relies on a change in the law as its basis or if the request is received by the PRRB more than three years after the date of the determination at issue.
- Although CMS may review the PRRB's decision to grant or deny an extension, such a determination by the PRRB or CMS is not subject to judicial review.

Group Appeals (§ 405.1837)

- *Right to a Hearing:* A provider has a right to a hearing as part of a group appeal if it satisfies the dissatisfaction and timely filing requirements as established for a single provider appeal.
- *Issues:* Group appeals are limited to one legal or factual issue common to all providers in the appeal.
- *Years:* One or more providers in a group may, as a matter of right, include more than one cost year in a group appeal for the purpose of meeting the $50,000 amount in controversy requirement. One or more providers in a group may, subject to PRRB discretion, include more than one cost year in a group appeal for other purposes, such as convenience.
- *Transfer back to Individual Appeals:* Once part of a group appeal, the provider will not be allowed to transfer its issue to an individual appeal unless the PRRB determines that the requirement for a group appeal have not been met.
- *Mandatory Group Appeals:*
    - Related parties wishing to appeal an issue that involves a common fact or interpretation of law, arises in a cost reporting period ending in the same calendar year, and has an aggregate amount in controversy of $50,000 or more, must bring the appeal as a mandatory group appeal.
    - Only related providers can be included in a mandatory group appeal.
    - If a provider in a mandatory group appeal includes more than one year in the appeal, the other related providers must also include the issue for the additional year in that appeal if they wish to appeal that issue.
    - The PRRB will close the group upon notice from the group that it is fully formed, or may close the group after giving it an opportunity to demonstrate that a related party that should be in the group has not yet received its NPR or the deadline for appeal has not yet run. Once the group is closed, absent an order from the PRRB, no other related party may appeal the issue for the same year that is the subject of the group appeal.

Amount in Controversy (§ 405.1839)

- In an individual appeal, the $10,000 amount in controversy

jurisdictional requirement, i.e., the additional reimbursement the provider would receive if successful in the appeal, is calculated based on the aggregate amount of the adjustments being appealed by the provider for a single cost year. Providers may aggregate adjustments across multiple cost years for purposes of meeting the $50,000 amount in controversy requirement for group appeals.

- Any effect on reimbursement in a year other than the one under appeal, has no bearing on the amount in controversy. Note: this would mean that future reimbursement effect based on revisions to a current cost report e.g., resident full-time equivalent count, cannot be included in the calculation of the amount in controversy.

- The PRRB retains jurisdiction over appeals, notwithstanding that the amount in controversy falls to an amount less than $10,000, when the change in the amount in controversy is due to partial settlement, transfer of one or more issues to a group appeal or abandonment of one or more issues. If the change in the amount in controversy reflects a mistaken initial assessment, the PRRB does not retain jurisdiction.

Expedited Judicial Review (§ 405.1842)

- Upon receiving a request for expedited judicial review, the PRRB has thirty days either to rule on the request or to issue notice to the provider that it has not submitted a complete request, describing in detail the additional information that is necessary.

Parties to a Hearing (§ 405.1843)

- The PRRB determines whether an organization is a “related party" in accordance with Section 413.17.

- CMS is not a party to PRRB hearing.

- The intermediary may designate a representative from the Secretary of Health and Human Services or CMS to represent the intermediary before the PRRB.

- CMS may file an *amicus curiae* briefing paper with the PRRB.

Quorum Requirements (§ 405.1845)

- The PRRB Chair may designate one or more PRRB members to conduct a hearing without the provider’s or intermediary’s consent.

- A quorum of at least three PRRB members, one of whom is representative of providers, must issue a final decision.

- The PRRB may conduct a hearing on the written record if both parties agree to waive an oral hearing.

Proceedings Prior to Hearing; Discovery; Subpoenas (§§ 405.1853, 405.1857)

- *Preliminary Narrowing of Issues:* Upon notice of a provider’s hearing request, the intermediary must attempt to join with the provider to submit stipulations and must ensure that evidence considered by the intermediary or Secretary in making its determination are included in the record.

- *Position Papers:* The PRRB will establish due dates for position papers. Exhibits supporting jurisdiction for each issue must accompany the position paper; exhibits addressing the merits may be submitted pursuant to a schedule adopted by the PRRB.

- *Status Conferences:* The PRRB may conduct an initial status conference after filing of the position papers and may conduct subsequent conferences at its discretion.

- *Discovery and Subpoenas:*

    - The Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance.

    - No discovery or subpoena is permitted against CMS, the Secretary or any federal agency, as this could cause disruption to their day-to-day activities or could result in further backlog of cases before the PRRB. CMS believes the Freedom of Information process is adequate for this purpose.

    - Depositions are permitted only where deponent agrees to the deposition or the PRRB determines it is necessary to secure the testimony for hearing, and must be conducted no later than 45 days before the initially scheduled hearing, unless the PRRB directs otherwise.

    - Discovery requests must be served no later than 120 before the initially scheduled hearing date, unless the PRRB extends the time, and responses must be served no later than 45 days before the initially scheduled hearing, unless the PRRB directs otherwise.

    - Generally discovery and subpoena rulings are reviewable by the Administrator only as part of a final PRRB decision. However, where the ruling authorizes the discovery or subpoena, and the objection is based on privilege, other protection from disclosure such as case preparation, confidentiality or undue burden, the ruling may be reviewed immediately by the Administrator.

PRRB Actions in Response to Failure to Follow Rules (§ 405.1868)

- If a provider fails to meet filing deadlines or other requirements, the PRRB may dismiss with prejudice.

- If an intermediary fails to meeting filing deadlines or other requirements, the PRRB may issue a decision based on the written record submitted at that point.

- *Ex parte* communication with PRRB staff regarding procedural matters is not prohibited.

PRRB Hearing Decision (§405.1871)

- The decision must determine whether the provider met its burden to establish its case by a preponderance of the evidence.

- If the decision departs from CMS instruction that would be dispositive, the decision must explain how it gave great weight to the CMS interpretation but did not uphold the intermediary's position.

Administrator Review (§ 405.1875)

- The Administrator may review only final PRRB decisions, unless otherwise noted in the regulations.

Judicial Review (§ 405.1877)

- A provider is not required to seek Administrator review in order to obtain judicial review.
- Intermediary determinations that certain expenses are not covered costs are not subject to PRRB or judicial review.
- PRRB remand orders, PRRB or Administrator discovery, disclosure or subpoena rulings are limited to review within the context of a final agency decision.

Reopening of Intermediary Determination or Reviewing Entity Decision (§§ 405.1885, 405.1889)

- Changes in CMS policy or interpretation of regulations, CMS Ruling or general instructions are not bases for reopening a determination.
- CMS has the ultimate authority to direct an intermediary to reopen or not reopen a determination.
- The decision as to whether to reopen a determination is not subject to further administrative or judicial review.
- Notice of reopening for an “own motion" reopening not involving fraud or similar fault must be mailed no later than three years after the date of the determination.
- Requests to reopen not involving fraud or similar fault must be received within three years after the date of the determination.
- CMS or an intermediary may reopen a determination that is pending before the PRRB or Administrator. An intermediary may also reopen a determination for which no appeal has been taken if the deadline for filing an appeal has not yet passed.
- The intermediary or reviewing entity must notify the parties of a reopening and allow the parties to present additional evidence.
- Any matter considered in a reopening, but not revised, is not appealable through the revised determination.

Ober|Kaler's Comments: Many of the new regulations appear one-sided, restricting providers’ rights to pursue appeals before the PRRB, so as not to overburden CMS and intermediaries and in order to reduce the PRRB’s caseload. It is likely some of these new regulations will ultimately be challenged in court as impermissibly restricting a provider’s statutory right to appeal and the PRRB's statutory scope of jurisdiction. In the meantime, however, providers need to identify all of the potential issues they wish to appeal and include them in the appeal of the determination, since adding issues at a later time will be severely restricted. Providers with appeals pending as of August 21, 2008, must add all issues they wish to add by the later of (a) 60 days after expiration of the 180-day appeal period or (b) October 20, 2008. Providers also need to be sure to closely abide by the requirements for filing appeals, to avoid the risk of the appeal being dismissed with prejudice

for failure to include all of the requisite information and documentation in the initial appeal letter. The PRRB has indicated its intention to issue revised Instructions, based on the new regulations, possibly as soon as the effective date of the new regulations, so providers should be on the watch for these new instructions in the near future.