

HEALTH INDUSTRY ALERT

CMS ISSUES LONG-AWAITED REVISIONS TO PRRB APPEAL PROCEDURES



On May 23, 2008, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule implementing revisions to the rules governing Medicare reimbursement appeals before the Provider Reimbursement Review Board (PRRB, or the Board). *See* 73 Fed. Reg. 30,190 (May 23, 2008) (located at <http://edocket.access.gpo.gov/2008/pdf/E8-11227.pdf>). This rule finalizes the proposals CMS issued back in June 2004. Since these regulations may have significant implications for your institution, this Alert provides a summary of the highlights of this Final Rule. Notably, the American Health Lawyers Association is hosting a two-part teleconference that will review the new PRRB rules in greater detail. The teleconference dates are June 17th and July 31st, and Akin Gump will be presenting at the opening session. You can register online at <http://www.healthlawyers.org/email/pg/080603/register.cfm>.

BACKGROUND

The rationale for amending its PRRB regulations lies in CMS' belief that since they are more than 30 years old, and many of the regulations have been the subject of extensive litigation, it was necessary to reexamine and update the rules. CMS is also motivated by the "huge backlog" of PRRB cases, which it stated was approximately 6,800 cases. CMS believes that these revisions will lead to a more efficient appeals process and will help decrease the backlog of cases. The justification for many of the changes described below is, on the one hand, maximizing efficiency in the appeals process, and, on the other, eliminating outdated material and clarifying policies. Notably, even without these new rules the case backlog has dropped by approximately 3,300 cases in the past five years. Further, given that the present system results in the administrative resolution of well over 90 percent of the cases, thus avoiding the need for PRRB hearing and further litigation, it seems to be working quite well. It is unclear whether these revisions will have the impact CMS expects, but it would clearly not be positive for providers if the implementation of these new rules resulted in more red tape and fewer settlements.

REVISED INITIAL APPEAL PROCEDURES

Perhaps the most important change for providers in this rule is the time limitation on adding issues to an appeal before the Board. Currently, a provider can add issues anytime before the hearing date, which often means several years from the date of filing. Under the new regulations, issues may only be added to an appeal for a period of 60 days after the expiration of the original 180-day appeal period. Thus, providers would have a total of 240 days after the issuance of the Notice of Program Reimbursement (NPR) to add issues to an appeal. There are no exceptions to this time

limit, whether for good cause or for any other reason. CMS believes this will allow for “efficient administration of the appeals process” and will assist the Board in managing the sizeable backlog in its caseload.

Although this revision does not seem unreasonable when compared to analogous procedural rules in other administrative or court jurisdictions, given that, for over 30 years, providers have had the right to add issues to PRRB appeals at any time before hearing, this change will certainly impact providers’ rights to seek redress of improper Medicare determinations. This change will require providers to plan ahead, as there will only be a short window to add issues after the hearing request is filed.

There are also significant revisions regarding the hearing request requirements. First, providers must now demonstrate through both argument and supporting documentation that all jurisdictional requirements are satisfied. In addition, hearing requests will have to contain a description and the nature of each self-disallowed item, as well as the reimbursement amount sought for that item, and a copy of the NPR or final determination under appeal. If the hearing request is for a group under common ownership or control, the providers will have to include information regarding the parent corporation and a statement acknowledging that no other related provider has a pending appeal on the same issue for the same timeframe, or will have to provide information about a pending appeal, if one exists.

These procedures are less onerous than the proposed rules, which seemed to require initial hearing requests that were closer to position papers in the amount of argument and documentary support needed to file a proper appeal. Although many providers’ hearing requests already provide the information now required under the rules, providers must now make sure that all required documentation and argumentation is included in the hearing request.

Providers still have the right under the new rules to present a request for a good cause extension of time to file a hearing request. The appeals period will be extended for good cause only due to extraordinary circumstances beyond the provider’s control. The request for extension of time will have to be made within a reasonable time beyond the original 180-day period, and the request will not be granted if it is made more than three years after the date of the NPR or other determination being appealed. These timeframes are the same as under the current rules. The Board will not be allowed, however, to grant a good cause extension if a provider bases the request on a change in law, regulations, CMS rulings, CMS instructions or any other federal legal provisions. A decision by the Board regarding a good cause extension can be reviewed by CMS but will not be subject to judicial review.

In another significant change, CMS is now requiring providers to either claim items on the cost report where reimbursement is sought in accordance with Medicare policy or self-disallow those items where reimbursement is sought that the provider believes is not in accordance with Medicare policy. More simply, any item that a provider plans to appeal must be claimed on the cost report. Those items that are self-disallowed must be claimed by following the procedures in the Provider Reimbursement Manual, Section 115, which are the instructions for claiming a protested item. This is important to note in order to preserve all appeal rights. If these cost reporting requirements are not followed, the Board will find that it does not have jurisdiction over the issue. Notably, this new requirement will be effective for all cost reporting periods ending on or after December 31, 2008.

GROUP APPEALS

CMS has revised a number of procedural matters related to group appeals. One or more providers may now include more than one fiscal year in a single group appeal either to meet the \$50,000 group jurisdictional threshold or simply as a matter of convenience. Although this practice has been occurring informally over the past few years, it is now expressly covered by the rules.

With respect to when a group is complete, the Board may issue an order to determine when a group is fully formed. CMS has given the PRRB more discretion to grant or deny a request from a provider to join a group appeal. In addition, if the Board determines that the jurisdictional requirements for a group appeal are not met, the issue that was the subject of the group appeal will be transferred to individual appeals for those providers that meet the requirements for a single provider appeal. Outside of those circumstances, however, a provider cannot transfer an issue from a group appeal to a single provider appeal.

Notably, the revised timeline for adding an issue impacts group appeals as well. If a provider with a pending individual appeal wants to add an issue and transfer it to a group appeal, that must be done within 60 days after the expiration of the original 180-day appeal period.

TIMING

The regulation governing Calculating Time Periods and Deadlines (42 C.F.R. § 405.1801(a) and (d)) will be revised to provide that the “Date of Receipt” of a filing when using a “nationally-recognized next-day courier service” is presumed to be the date of delivery noted by the courier. If a next-day courier is not employed, the “Date of Receipt” shall be presumed to be the date stamped “Received” by PRRB, unless there is clear and convincing evidence establishing that the materials were actually received on a different date. The Board’s determination as to whether clear and convincing evidence exists to prove receipt on a different date is not subject to further administrative or judicial review. CMS is strongly encouraging providers to send all filings to the PRRB by a “nationally-recognized next-day courier service.”

PRE-HEARING ISSUES

Discovery is dramatically limited to a request for the production of documents from a party or nonparty, a reasonable number of written interrogatories from a party and depositions of a party or nonparty (if the deponent agrees or the Board finds the deposition necessary). Requests for admissions or other forms of discovery are not allowed. The rules strictly provide that the discovery procedures “will not apply to CMS, the Secretary (or any other component of HHS), or any other Federal agency.” Instead, CMS has determined that the Freedom of Information Act (FOIA) process “will meet providers’ needs for gaining access to information” in the government’s possession. Of course, for anyone who has dealt with the FOIA process, this conclusion is laughable.

Discovery deadlines have been revised as well, with the significant reference date being the initially scheduled hearing date. Under the new rules, a party must serve its discovery request no later than 120 days before the initially scheduled hearing date, and the discovery responses must be served no later than 45 days of that initially scheduled hearing date. A request for a subpoena must be received by the Board by 120 days from the initially scheduled hearing date. As such, even if the hearing date is moved, all discovery deadlines will still reflect the original date.

CMS declined to dictate deadlines for position papers or PRRB decisions. Both timeframes continue to be left to the Board’s discretion.

The intermediary will now be able to designate a representative from CMS to defend the intermediary’s position at the PRRB. In addition, CMS will be able to file amicus curiae briefs where CMS was not formally designated the representative. Nonparties, other than CMS, will be allowed to seek leave from the Board to file amicus curiae briefing papers. These amicus curiae briefs may be excluded by the Board from the administrative record; however, if the Board excludes CMS’ amicus curiae brief, it must include its reasons for the exclusion in the record.

CMS has given the PRRB explicit authority to act in response to either party’s failure to follow the Board’s rules. If a provider fails to meet a filing or procedural deadline or other requirement set by the Board, the Board may dismiss the hearing request or take other appropriate action. If the intermediary fails to meet a filing or procedural deadline or other requirement set by the Board, the Board will have the right to issue a decision based on the written record submitted to that point or take other appropriate action. It is within the Board’s discretion to allow a party to submit late evidence or arguments. The authority to act when an intermediary fails to meet a deadline is a significant change, as currently intermediaries suffer little consequence for failing to follow the Board’s rules. Of course, it will be interesting to see if and how the PRRB wields this authority.

PRRB HEARING

The PRRB may now designate one Board member to conduct a hearing to allow for more than one hearing to be held simultaneously. However, a quorum of at least three Board members (at least one of whom is representative of providers) will still be required to issue a decision. The designation of a one Board member hearing would not require the approval of the provider or the intermediary. Whether the Board takes advantage of this procedure and whether it results in the Board issuing more decisions and reducing the backlog of cases is an open question.

REOPENINGS

The reopening regulations are also being revised under this Final Rule. Providers will no longer be able to seek reopenings based on a change in legal interpretation or policy by CMS in a regulation, ruling or instruction. CMS states that, as court rulings have made clear, reopening decisions are not subject to administrative or judicial review, and CMS is the final authority regarding whether an intermediary may or may not reopen a determination. CMS also notes that it will not mandate timeframes for intermediaries to respond and process reopenings, due to the large workloads of intermediaries.

The Final Rule is lengthy and contains a significant number of changes to the appeals process. Providers will need to use more advance planning in structuring Medicare appeals — from including items “properly” on the cost report to the new requirements of what to include in the hearing request, to the significantly shortened timeframe in which new issues can be added to a pending appeal. The Board has given more discretion in certain aspects of appeals, which appears to be a positive development from the 2004 proposed rulemaking. Furthermore, the Board’s new authority to penalize an intermediary for failing to follow Board procedures is certainly a noteworthy change.

The new rules will become effective on August 21, 2008, and will apply to all pending appeals and appeals filed on or after that date. CMS notes in the Final Rule that if any of these revisions conflict with current PRRB Instructions, then these new PRRB rules govern. However, we expect that the Board will issue revised Instructions that will both reflect the changes in the regulations and provide further guidance in areas where the new rules are either silent or on issues that were left to the Board’s discretion. We understand that such new Instructions could be released in some form as early as July, but it is not clear what opportunity the public will have to comment on the new Instructions before they are issued in final form. We will issue another Alert when the revised PRRB Instructions are released.

CONTACT INFORMATION

If you have any questions about the revised PRRB rules and their impact on your appeals, please contact:

John R. Jacob 202.887.4582 jjacob@akingump.com Washington, D.C.
Elizabeth H. Goldman 202.887.4423 egoldman@akingump.com Washington, D.C.

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