

From *Bethesda* to Gotcha: CMS Proposes Significant Amended Rules Regarding Claiming Payment on Cost Reports and Filing Appeals with the Contractor or the Provider Reimbursement Review Board¹

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Introduction

More than 25 years ago, in *Bethesda Hospital Association v. Bowen*, the U.S. Supreme Court held that a provider had the right to appeal any matter covered by a cost report, including matters for which the provider “self disallowed,” i.e., the provider did not waive its appeal rights regarding one or more items by filing the cost report in compliance with applicable law regarding such items.² In ensuing years, the Centers for Medicare & Medicaid Services (CMS) and the Provider Reimbursement Review Board (PRRB or Board) established rules, policies, and procedures that have cumulatively eroded *Bethesda* and erected barriers to the appeals process that seem to place form over substance. That is, rather than principally devoting resources to adjudicating substantive payment disputes, arguably the PRRB devotes a disproportionate effort to scrutinizing whether a provider satisfied procedural and jurisdictional requirements. Most notably, as part of a 2008 major overhaul of the regulations governing PRRB appeals procedure, a prerequisite to self-disallowance for appeals of cost reporting periods beginning on or after December 31, 2008 is the requirement that a provider “present” a self-disallowed issue as a protested item in the cost report.³ The upshot is that a dramatic shift has taken place the past quarter century from the broad appeal

¹ This article is not intended to furnish legal advice. Readers wishing to discuss this article may contact the author at kmarcus@hongiman.com.

² See *Bethesda Hospital Association v. Bowen*, 484 U.S. 399 (1988).

³ See 42 C.F.R. § 1835(a)(1)(ii); PRRB Rules, Section 7.2C.

rights the Supreme Court recognized in *Bethesda* to what, in a very practical sense, has become a game of “gotcha” in which one misstep can result in forfeiture of appeal rights and Medicare payment. The procedural requirements for asserting and pursuing an appeal are reminiscent of the long-abandoned common law Forms of Action, in which the “form” of the action outweighed the cause of action. As a result, cost report filing requirements have become conditions of payment, and thus CMS may deny payment to a provider who fails to satisfy such procedural requirements.

The *Bethesda* erosion process continues. On April 30, 2014 CMS issued a display copy of, and on May 15, 2014 published in the Federal Register, the Federal Fiscal Year 2015 Hospital Inpatient Prospective Payment Rule providing for significant proposed amendments to the rules: (1) for claiming costs on the hospital cost report by adding new paragraph (j) to 42 C.F.R. § 413.24; and (2) regarding the procedure for filing appeals concerning such claims with the Contractor (the new generic name for entities such as the Intermediary or the Medicare Administrative Contractor) or PRRB.

The sum and substance of these proposed regulations is to increase the complexity of the cost report filing and appeals process, with a heightened need for vigilance by the provider and its representatives in identifying, asserting, preserving, and pursuing its appeal rights. Pursuant to the Medicare Part A appeals statute, 42 U.S.C. 1395oo(a), a final payment determination triggers the appeal right, typically, a notice of program reimbursement (NPR). Providers usually seek assistance from legal counsel upon receipt of the NPR. Under these proposed rules, however, the scope of the appeals process, in large part, will begin with and will be determined by the cost report filing. To assure effective appeals, therefore, assistance from legal counsel will be required at the cost report filing stage.

Providers and their representatives should carefully review the CMS explanation of these proposed rules as well as the proposed codified rules themselves and consider filing comments by the applicable deadline, which is June 30, 2014. An overview follows:

Cost Report Claims: 42 C.F.R. § 413.24(j)

CMS proposed adding a new paragraph (j) to the regulation at 42 C.F.R. § 413.24, which establishes the substantive reimbursement requirement for an appropriate cost report claim. The provider must either “[c]laim. . . . full reimbursement in the provider’s cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy” or “[s]elf-disallow. . . . the specific item in the provider’s cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the Contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item)” 413.24(j)(1).

The proposed rule, 413.24(j)(2), specifies the procedural requirements for a self-disallowed claim by requiring that the provider:

1. Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider’s cost report; and
2. Attach a separate worksheet to the provider’s cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

Paragraph (3) of the proposed rule then prescribes the procedure for determining the presence of an appropriate cost report claim where (1) the provider submits an amended cost report accepted by the contractor, (2) the contractor adjusts the original or amended cost report; and (3) the contractor reopens and adjusts the cost report.

Paragraph (4) of the proposed rule provides for the reimbursement effects of the contractor’s determination of whether the provider filed an appropriate claim under the following scenarios:

- If the contractor determines that the provider's cost report included an appropriate claim for a specific item (as specified in paragraphs (j)(1), (j)(2), and (j)(3) of this section) and that all the other substantive reimbursement requirements for the specific item also are satisfied, the final contractor determination (as defined in § 405.1801(a) of this chapter) must include reimbursement for the specific item to the extent permitted by Medicare policy.
- If the contractor determines that the provider made an appropriate cost report claim for a specific item, but the contractor disagrees with material aspects of the provider's claim for the specific item, the contractor must make appropriate adjustments to the provider's cost report and include reimbursement for the specific item in the final contractor determination in accordance with such cost report adjustments and to the extent permitted by program policy.
- If the contractor determines that the provider did not make an appropriate cost report claim for a specific item, the final contractor determination must not include any reimbursement for the specific item, regardless of whether the other substantive reimbursement requirements for the specific item are or are not satisfied.

Finally, Paragraph (5) provides for administrative review of whether there has been an appropriate cost report claim by requiring the reviewing entity to follow the procedures in Paragraph (3) of the proposed rule.

If adopted in substantially the same form as proposed, new paragraph (j) will greatly increase the importance of the cost report filing process by linking it strongly with the appeals process.

Right to a Contractor or PRRB Hearing 42 C.F.R. §§ 405.1835 *et seq.*

The requirements for claiming costs set forth in proposed rule 413.24(j) directly impact the procedural and substantive requirements governing the provider's right to a hearing

before the contractor or PRRB.⁴ Importantly, CMS proposes to add a new section, 405.1873, which provides for the PRRB's review of whether the Provider complied with the requirements of 413.24(j), *which the PRRB will review as a condition of payment rather than as the bases for determining jurisdiction*. This proposal reflects a major paradigm shift.

Paragraph (a) of 405.1873 provides that if any party to an appeal "questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section." Notably, this provision is silent on whether the Board, on its own motion, can raise this question.

Paragraph (b) of 405.1873 prescribes the Board's procedures for addressing a party's question of whether a claim was appropriate.

- The Board must give the parties an opportunity to submit factual evidence and legal arguments, on which the Board must issue findings of fact and law based on the provisions or 413.24(j)(3).

The PRRB's findings of fact and law are not the bases for dismissing the provider's claim. Rather, upon issuing its findings to the parties, PRRB must issue one of four types of decisions. Here, it becomes complicated regarding the PRRB-prohibited and -required actions. Carefully review the four types of PRRB decisions referenced in the proposed rule.

- First, PRRB is prohibited from denying jurisdiction or declining to assert jurisdiction based on factual and legal findings under the standard established by 413.24(j)(3).
- If PRRB issues a hearing decision or a decision granting expedited judicial review (EJR), it must include its findings of fact and conclusions of law regarding 413.24(j)(3).

⁴ For a Contractor hearing, less than \$10,000 is in dispute. This discussion focuses on the rights to a PRRB hearing.

- If the PRRB issues a jurisdictional decision or a decision denying EJR, PRRB may not include its findings of fact and conclusions of law in the decision.

Paragraph (f) of 405.1873 provides for the effects of the PRRB's findings of fact and conclusions of law regarding whether the provider complied with 413.24.

- If the PRRB finds that the provider complied, "the specific item is reimbursable in accordance with Medicare policy, but only if the Board further determines in such final hearing decision that all the other substantive reimbursement requirements for the specific item are also satisfied."
- If the PRRB finds that the provider "[did not include an appropriate cost report claim for the specific item under appeal, then the specific item is not reimbursable, regardless of whether the Board further determines in such final hearing decision that the other substantive reimbursement requirements for the specific item are or are not satisfied."
- In the case of EJR, whether the item is reimbursable ultimately hinges on whether the provider complied with 413.24.

If adopted in substantially the form proposed, the resources of PRRB will become more greatly devoted to resolving the question of "what did the provider claim, and when did the provider claim it?"

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