

## CMS Publishes Amended Cost Reporting and Appeal Rules

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The November 13, 2015 Federal Fiscal Year 2016 Outpatient PPS Final Rule included surprise provisions significantly amending the Medicare Part A cost reporting and appeals process. The Centers for Medicare and Medicaid Services has proposed the amended rules as part of the Fiscal Year 2015 Inpatient PPS, but did not issue them in final form. The amended cost reporting rules are effective for cost reporting periods beginning on or after January 1, 2016, and the amended appeals rules apply to such cost reporting periods. Hospital financial managers, their consultants and legal counsel should fully familiarize themselves with these significantly revised regulations.

### *The Amended Cost Reporting Rule*

CMS has added a new paragraph (j) to the regulation at 42 C.F.R. § 413.24, which for the first time provides that the contents of the cost report establish a substantive reimbursement requirement for an appropriate cost report claim and which requires the PRRB to review the cost report as such a requirement as opposed to a jurisdictional requirement. Paragraph (1) of this rule provides that 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) . . . .”

Thus, the provider must “claim or explain,” *i.e.*, if the provider does not claim payment for

an item, the provider must self-disallow. Paragraph (2) specifies the procedural requirements for a self-disallowed claim. Paragraph (3) establishes that whether a cost report claim is appropriate “must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period” unless the provider submits and the MAC accepts an amended cost report. Paragraph (4) establishes the reimbursement effect of the Provider’s claim by establishing three options for the MAC. First, the MAC must allow reimbursement “[i]f the contractor determines that the provider’s cost report included an appropriate claim for a specific item and that all the other substantive reimbursement requirements for the specific item are also satisfied . . . .” Second, the MAC must make an appropriate adjustment “[i]f 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 . . . .” Finally, [i]f 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.*” (Emphasis added.) Paragraph (5) provides that if “any party” . . . “questions whether the provider’s cost report included an appropriate claim for the specific item under appeal” then the “reviewing entity” (*i.e.*, either the PRRB or the MAC for appeals with Medicare impacts of less than \$10,000) “must follow the procedures prescribed in § 405.1873 (*i.e.*, the amended PRRB appeals regulation if the appeal is filed with the PRRB) or the procedures set forth in § 405.1832 (*i.e.*, the amended appeals regulation if the appeal was filed initially with the contractor).” Significantly, the review entity’s determination must be based on a provider’s compliance with the cost reporting requirements of new 413.24(j)

### *The Amended Appeals Rule*

The rules were amended for PRRB appeals and for appeals alleging a Medicare impact of less than \$10,000 that may be appealed before the contractor. This article's focus is the amended rule for appeals before the PRRB, and specifically amended rule 42 C.F.R. § 405.1835, the new rule 42 C.F.R. § 405.1873 entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim" and the amended rule regarding CMS Administrator review of a PRRB decision, 42 C.F.R. § 405.1875(a)(2)(v), which reflects the amended cost report and appeals rules.

First, CMS amended 42 C.F.R. § 405.1835 by deleting the jurisdictional requirement that a provider must include a protested amount in order to self-disallow a reimbursement item. In doing so, CMS commented that: "it is reasonable to eliminate the Board jurisdiction requirement in existing [the existing rule] of an appropriate cost report claim. We note that once this amendment to the Board appeals regulations becomes effective, this proposal will facilitate an orderly end to any litigation regarding the Board jurisdiction requirement of an appropriate cost report claim."

Second, CMS promulgated an entirely new section, 42 C.F.R. § 405.1873, which prescribed in exacting detail the PRRB's review of whether the Provider complied with the requirements of 413.24(j). The PRRB's preliminary procedures are prescribed by the amended rule. First, the PRRB must give the parties an opportunity to submit factual evidence and legal arguments, on which the PRRB must issue findings of fact and law based on the provisions or 413.24(j)(3). *I.e.*, the PRRB's focus is restricted to the provider's cost report. Second, the PRRB's "specific findings of fact and conclusions of law . . . must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction over a specific item or take any other of the actions specified in paragraph (c) of this section." Significantly, The PRRB's

findings of fact and law *will not be the bases for dismissing the Provider's claim*. Instead, the PRRB is required to issue one of four types of decisions. The four types of decisions are: a hearing decision, an expedited judicial review (“EJR”) decision granting EJR, a jurisdictional dismissal decision, and a decision deny denying EJR. The reader should carefully review the regulation and the accompanying CMS commentary. In summary, if the PRRB issues either a hearing decision or a decision granting expedited judicial review (“EJR”), it must include its findings of fact and law. Otherwise if the PRRB issues a decision dismissing on jurisdictional grounds or denying EJR, it must not include its findings of fact or law. The revised rule also prohibits the PRRB from issuing specific types of decisions, orders and other actions. Thus, if the PRRB finds that the cost report did not include an appropriate claim for the specific item under appeal, the PRRB may not, based on that finding, deny jurisdiction over the item, decline to exercise jurisdiction over that item, or impose sanctions (including the sanctions specified in 42 C.F.R. 405.1868(b), (c), or (d)) except as provided in (f).”

#### *The Amended Rule Regarding CMS Administrator Review*

The final decision of the PRRB is subject to review by the CMS Administrator. The applicable rule, 42 C.F.R. 405.1875(a)(2)(v), was amended to provide that the decision of the Administrator “will address, the Board’s specific findings of fact and conclusions of law in such hearing decision or EJR decision . . . on the question of whether the provider’s cost report included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter).”

#### *Conclusion*

Under the new rule 413.24(j), the appeals process commences with the cost report filing. To ensure effective appeals, therefore, financial managers should seek assistance from legal and consulting counsel at the earlier cost report filing stage rather, as was typical, when the NPR is issue. These new rules apply to the provider's fiscal year beginning 1/1/2016. Providers, along with their legal and consulting representatives, should familiarize themselves with these rules to assure compliance for payment and appeals purposes.

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