PRRB Appeals: New Challenges

American Health Lawyers Association
Institute on Medicare & Medicaid Payment Issues
March 25-27, 2015

Mark Korpela
Melanie Marolf-Fetchik
Lisa Ogilvie
Stephanie Webster

Overview of Topics

• Jurisdictional/Procedural Requirements and Emerging Trends
• Group Appeal Pitfalls
• MACs and the Role of the Appeals Support Contractor
• Reopenings of Appealed Issues
• Avoiding Procedural Snafus
Jurisdiction?

➢ Statutory Jurisdictional/Procedural Requirements
  • Dissatisfaction with final payment determination
  • Timely appeal--180 days from receipt of final determination
  • Requisite amount in controversy--$10K for individual; $50K for group

Jurisdiction?

➢ Regulatory Jurisdictional/Procedural Requirements
  • Regulations effective for cost reporting periods ending on or after 12/31/2008
    • Original NPR
      • claimed item and audit adjustment in NPR; or
      • protested item
    • Revised NPRs
      • only matters specifically revised are within the scope of an appeal (not within scope if “reopened but not revised”)
Jurisdiction?

Cost Report Protest Items
- Program manual instructions for cost report protest items (Board Rule 7.2.C; Provider Reimbursement Manual, Part II, §§ 115, 360.1)
  - Identify each protested issue/self-disallowed item
  - State reimbursement impact for each issue
    - PRM: “reasonable methodology which closely approximates the actual effect”
  - Provide work papers showing calculation of impact
    - PRM: contractor may “evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable”

Jurisdiction?

Appeals of Protest Items
- Other requirements for protested item appeals (Board Rule 7.2)
  - Concise issue statement
  - Reimbursement impact
  - Authority “that predetermined that the claim would be disallowed”
  - Cost report protested item page and workpapers (Board Rule 21.D.2 requirement for group Schedule of Providers)
Jurisdiction?

- Board Alert 10 (May 23, 2014)
  - “Dissatisfaction” where no protest item
  - DSH Medicaid eligible days appeals
  - “Opportunity” for providers to supplement record supporting jurisdiction
  - “Practical impediment” standard of Danbury

Jurisdiction?

- Board Alert 10-specific details requested
  - Detailed description of process to identify Medicaid eligible paid and unpaid days on as-filed CR
  - Number of days
  - Detailed explanation of why days could not have been verified when CR filed (by category of days)
Jurisdiction?

- Post Board Alert 10
  - Hearing held for Barberton Citizens Hospital on November 20, 2014. Record and testimony documented “concept of futility” in obtaining Medicaid eligible paid and unpaid days on as-filed CR
  - 2015-D5 issued March 19, 2015
  - Barberton vs. BCBSA finds that provider established that practical impediment, through no fault of its own, prevented provider from verifying all Medicaid eligible days prior to filing of the cost report

Jurisdiction?

- Appeals from untimely NPRs
  - No “dissatisfaction” requirement
    - Regulation amended as part of the 2015 IPPS Final Rule
    - Correction to bring the regulation in line with statute
    - Effective for all appeals that were initiated or pending on or after August 21, 2008 effective date of the previous regulation change
      - Subject to the reopening rules
  - 180 days from anniversary of cost report filing (receipt of “perfected cost report”)
  - Must document date of receipt of cost report and proof of acceptance
Jurisdiction?

- Emerging Trends at the Board
  - Appeals from revised NPRs
    - New Board Rules for documentation in 2013
    - Make sure all documents required to establish jurisdiction are in record (whether on the Board’s list or not)
    - Board will use documents in record to make jurisdictional determination
  - Board “own motion” review
  - Timing of jurisdictional objections and responses (Board Rule 44.4)

Jurisdiction?

- Emerging Trends in Jurisdictional Objections/Decisions
  - “Dissatisfaction”—self-disallowed vs. unclaimed item
    - Pre-2008 regulation change
      - St. Vincent’s, PRRB 2013-D39 – Unclaimed ASC and Organ Costs
      - Danbury, PRRB 2014-D3 – Medicaid Eligible Days
    - Post 2008 regulation change–protest requirement
  - Identifying the specific issues (e.g., dual eligible, charity care, Medicare + Choice/MA)
Jurisdiction?

- Emerging Trends in Jurisdictional Objections/Decisions
  - Carry over issues (*e.g.*, prior/penultimate year)
  - Equitable theories (good cause, equitable tolling, mandamus)
  - Preclusion of review

Group Appeal Pitfalls

- Mandatory vs. optional groups
- Commonly owned/controlled providers
  - CIRP - mandatory Common Issue Related Party group
  - Related party—standard Medicare definition (42 C.F.R. § 413.17; PRM Part I Ch. 10)
  - No commingling of related and unrelated providers
Group Appeal Pitfalls

➤ One “Common” Issue
  • Single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (42 C.F.R. § 405.1837(b)(2))
  • Not common issue if Board could make different findings for different providers based on factual differences (Board Rule 13)
  • Board may allow a group appeal to encompass multiple years if no change in relevant law, but not multiple issues (multiple years must be approved by Board)

Group Appeal Pitfalls

➤ Certifications
  • None of the appealed issues are currently pending or were previously adjudicated, withdrawn or dismissed; and
  • No other related provider has pending appeal on the same issue(s) for the same calendar year

➤ Direct Adds to Groups
  • Cannot add issue at 240 day mark if no individual appeal
  • Board Rule 16.1.B and Model Form E (3/1/13)—must attach NPR or other final determination under appeal
Group Appeal Pitfalls

➢ Schedules of Providers
  • Documentation showing jurisdictional/procedural requirements met
  • Organized by lettered columns on cover schedule with corresponding tabs for supporting documentation
    A. Date of final determination
    B. Date of hearing request filing (documentation of delivery for appeals filed after 8/21/08—Board Rule 21.B)

➢ Schedules of Providers (continued)
  C. Number of days between final determination and appeal filing (receipt by Board if filed on or after 8/21/08)
     • For issues added to individual appeal then transferred to group, number of days from determination to add (21.C.)
  D. Audit adjustment number or protest item information
     • Additional documentation for revised NPRs (21.D.; see earlier slide)
  E. Amount in controversy
  F. Prior case numbers (Board Rule 21E)
Group Appeal Pitfalls

Schedules of Providers (continued)

G. Dates of Direct Add/Transfer
   - Paper trail showing how provider cost year added to group (new Board Rules 16.1, 21.G)
   - Direct adds to group (Board Rule 16.1.B)

H. Provider representative letter including year and issue (Board Rule 21.H)
   - Full copies to Board and lead MAC; cover schedule only to BCBSA (Board Rule 20.1)

Group Appeal Pitfalls

Designation of Lead MAC

- Greatest number of providers OR if tied, amount in controversy controls
- Designate lead MAC upon group formation, but may need modification later (e.g., when group complete)
- Notify old and new MAC if a lead MAC change
- Be as specific as possible, several MACs have multiple awards (ie. Novitas, J-H or J-L)
CMS Audit and Appeal Contractors

- **Medicare Administrative Contractors (MACs)**
  - Medicare Part A and Part B Services
  - Currently 12 contracts
- **CMS Appeals Support Contractor (ASC)**
  - Coordinates PRRB appeal activities and provides legal support to MACs
  - Currently BCBSA – Contract Re-compete
- **Program Safeguard Contractor (PSC)**
  - Special projects
  - Assists with audit and appeal backlogs
  - Cahaba Safeguard Administrators

Provider Assignment and MACs

- Generally, a provider is assigned to the MAC that covers the state where the provider is located.
  - Exceptions
    - Qualified Chain Providers – may elect to bill to one MAC
    - Provider may be “out of jurisdiction” but hasn’t been moved yet. It will move eventually
      - J5 – WPS – still contains many out of jurisdiction providers – Mutual of Omaha
    - Specialty Providers and Demonstrations
    - Home Health and Hospice – Regional MACs (previously RHHIs)
A/B MAC Jurisdictions
as of January 2015

Home Health and Hospice Jurisdictions
(Administered by A/B MACs)
A/B MAC Jurisdictions-PRRB Appeals Contractors

- JE Noridian (CA, NV, HI)
- JF Noridian (WA, OR, ID, AK, AZ, UT, WY, MT, ND, SD)
- JH Novitas (TX, OK, NM, CO, AR, LA, MS)
- J5 Wisconsin Physician Services (WPS) (KS, MO, NE, IA)
- J6 National Government Services (NGS) (IL, WI, MN)
- J8 WPS (IN, MI)
- JN First Coast Service Options (FCSO) (FL, Puerto Rico)
- J10/JJ Cahaba GBA (AL, GA, TN)
- J11 Palmetto (SC, NC, VA, WV)
- JL Novitas (PA, NJ, DE, MD, DC)
- JK NGS (NY, CT, ME, VT, NH, MA, RI)
- J15 CIGNA (CGS) (OH, KY)

- Appeals Support Contractor – Blue Cross Blue Shield Association (BCBSA)
- Program Safeguard Contractor – Cahaba Safeguard Administrators

Appeals Support Contractor (ASC) Contact information (as of November 7, 2013)

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>States</th>
<th>ASC Case Management</th>
<th>ASC Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Representative</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>1</td>
<td>CO, KS, KY</td>
<td>Ray Mathes</td>
<td>303.376.6232</td>
</tr>
<tr>
<td>2</td>
<td>FL, IL, IA</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>3</td>
<td>CA, NV, WA, OR, ID</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>4</td>
<td>MD, VA, WV</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>5</td>
<td>VA, NC, NC</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>6</td>
<td>IL, MI, W</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>7</td>
<td>NC, NC, NC</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>8</td>
<td>NC, NC</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>9</td>
<td>NC, NC</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>10</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>11</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>12</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>13</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>14</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
<tr>
<td>15</td>
<td>FL, GA, TN</td>
<td>Loree Stevens</td>
<td>312.207.8502</td>
</tr>
</tbody>
</table>

Executive Director: Kevin Shanklin 312.297.5716 kevin.shanklin@bcbsco.com
Reopening Appealed Issues

- Numerous questions – procedural issue
- Some providers file a both a reopening request and appeal for the same issue, same year, for various reasons.
- 42 CFR 405.1885(c)(3) – CMS or an intermediary may reopen...a Secretary or intermediary determination that is currently pending on appeal before the Board...
- Issues —
  - Appeal resolution follows a review process where the ASC approves the MAC proposal. Reopening does not necessarily follow the same process.
  - Volume (both appeals and reopening requests)
  - Limited resources
- Some issues may be candidates for reopening while under appeal, but it should not be expected. Many must follow the appeals process.

Payments to Providers - Reminder

- Medicare pays the current holder of the Medicare Provider Agreement
  - Payment follows the provider number (CCN)
    - If there was a change of ownership since the year under appeal, any payment would go to the current owner
  - MACs must follow the “normal process” and cannot establish a “workaround”
  - Payment cannot be made to an entity that is not the current provider
Avoiding Procedural Snafus

Provider representation requirements
- Only one representative per case (Board Rule 5.1)
- Must be submitted with the appeal
- Representation Letter signed by owner/officer on provider letterhead (Board Rule 5.4)
- Contemporaneous and appeal specific
  - For individual appeal, must identify provider’s fiscal year (Board Rule 5.4)
  - For group appeal, must identify provider’s fiscal year and issue (Board Rule 21.H—Tab H to Schedule of Providers)

Avoiding Procedural Snafus

Final determination appeal—must submit copy (405.1835(b)(3)) (No exceptions)
- NPR
- Revised NPR
- Federal Register
- Other final payment determination

Untimely NPR appeal—must document date of cost report receipt and acceptance (Board Rule 7.4)
Avoiding Procedural Snafus

➢ Expedited judicial review (Board Rule 42)
  - Statute—Board has jurisdiction but lacks “authority to decide question”
  - Decision 30 days from date of “complete” request for EJR
  - Filing EJR requests
    - Jurisdictional documents/statement
    - Regulatory requirements

Avoiding Procedural Snafus

➢ Filing correspondence with Board, MAC and BCBSA
  - PRRB requires hard copy correspondence. Any document filed with the Board must simultaneously be sent to opposing party and appeals support contractor (BCBSA)
  - BCBSA requests electronic filing as do many MACs (check with your MAC on their preference)
  - Multiple hard copies to Board for multiple cases (highlight case number)
  - 5 copies of position papers to Board 7-10 days before hearing (Board Rule 27.6)
  - Redact confidential information
    - Board requires redaction to avoid public disclosure
Avoiding Procedural Snafus

- **Withdrawal of Appeals**
  - It is the providers’ responsibility to know what issues are pending in their appeals
  - It is up to the provider to notify the Board when all issues have been transferred or withdrawn
  - If a provider transfers all issues from an appeal and fails to notify the Board (check box), the appeal will be dismissed if/when no position papers are filed

Avoiding Procedural Snafus

- **Postponements (Board Rules 23.5, 27.1, 30.3)**
  - Request for position paper extension must be requested:
    - in writing (letter)
    - 3 weeks prior to deadline
  - If no extension granted in writing, and no paper filed, case will be dismissed
  - Abeyance vs. postponement
  - Mediation approval will postpone all due dates
Avoiding Procedural Snafus

Postponements (Board Rules 23.5, 27.1, 30.3) (continued)

- Requests for hearing postponement may require approval of Board members, and may be granted due to:
  - Scheduling conflict
  - Documentation issues
  - Jurisdictional challenges
- Board expects parties to be ready
- Probable settlement does not guarantee
- Timetable/joint scheduling order

Avoiding Procedural Snafus

Remand Issues in Pending Appeals

- CMS Ruling CMS-1498-R (April 28, 2010)
  - Medicare DSH Appeals on SSI fraction data matching process, “non-covered” days in Medicaid fraction, labor and delivery days
  - Only appeals of NPRs that were issued prior to issuance of CMS-1498-R are subject to remand
  - If NPR was issued post ruling, Board cannot remand, must proceed on merits
- TDL-11456 (Sept. 6, 2011)
  - Appeals on labor and delivery days
QUESTIONS?

Presenters

- Mark Korpela  
  MKorpela@MSLC.com  
  (410) 581-4550

- Melanie Marolf-Fetchik  
  Melanie.Marolffetchik@cms.hhs.gov  
  (410) 786-5599

- Lisa Ogilvie  
  Lisa.Ogilvie@cms.hhs.gov  
  (410) 786-2922

- Stephanie Webster  
  SWebster@akingump.com  
  (202) 887-4049

Thank you!