

The RAP Sheet

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—from a declaration of the American Bar Association

Winners and Losers Under the PRRB's New Rules

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On May 23, 2008, the Centers for Medicare & Medicaid Services (CMS) issued new rules (regulations) revising Provider Reimbursement Review Board (PRRB or Board) procedures, effective August 21, 2008.¹ Subsequently, on August 8, 2008, the PRRB issued new instructions making a number of changes to the PRRB's procedures and the appeals process, also effective August 21, 2008. The new Board rules, numbering forty-nine at this article's writing, with various subparts, supersede all previous Board instructions.²

Together, CMS and the PRRB drastically changed virtually every aspect of the way a provider operates before the PRRB—from the filing of an appeal through the hearing. These are the most significant changes since the Medicare agency first enacted procedural rules governing the PRRB appeals process more than thirty years ago.³ In particular, the rules governing discovery are the most far reaching and potentially devastating to procedural due process rights since the PRRB regulations were first enacted.⁴

As CMS noted in the preamble to its May 23, 2008, pronouncement, there are approximately 6,800 appeals pending before the Board.⁵ What CMS did not discuss is that the appeals process has become a giant funnel—with roughly 1,500 new appeals filed with the Board each year. Approximately 100 cases are actually adjudicated by the Board annually—as most are settled and usually just before the scheduled hearing date. Based on these figures, it seems evident that the PRRB will make every attempt to further decrease its inventory. At the same time, the new changes could curtail meaningful discovery in Medicare policy cases and/or those where a great deal of money is at stake. Clearly, there will be winners and losers as a result of the new changes.

The Winners

The new regulations and instructions encourage communications between providers and fiscal intermediaries, routinizing certain types of communications, and require providers to develop appeals earlier in the process rather than shortly before the hearing, which has been standard practice since the Board became operational in 1975. There is a newly emphasized Board

expectation that the parties will communicate early, act in good faith, and attempt to negotiate areas of misunderstanding and differences. Providers must certify that this has been done. The new procedures apply to both individual and group appeals.

Who are the winners under the new rules? They can be narrowed down to those providers with the following characteristics:

- a. Providers that are organized and prepared regarding the appeal.
- b. Providers that are represented by experienced attorneys or consultants.
- c. Providers that have experience with the PRRB process.
- d. Providers that do not need extensive discovery from CMS and/or from the intermediary.

Obviously, those providers that are well organized regarding documentation/analysis of the issue[s] being appealed and are intimately familiar with the new Board regulations and rules are going to take these changes in stride, with the exception of the revision to the discovery rules. The new rules, in a sense, reward providers that file frequent cost report appeals, as well as law firms and advocates that are before the Board on a regular basis. As a result, those providers will become familiar with the specific minute rules and unpublished operating requirements. The new rules require detailed issue statements and arguments, as well as submission of virtually all evidence well in advance of the hearing.

It is important to note that the Board instructions now include seven model (but essentially mandatory) forms (Form A through G) covering individual and group appeal requests that providers or their representatives must fill out completely, and forms for adding or transferring issues in the appeal.⁶

The PRRB's New Model Forms	
Model Form A	Individual Appeal Request
Model Form B	Group Appeal Request
Model Form C	Request to Add Issue(s) to an Individual Appeal
Model Form D	Request to Transfer Issue to a Group Appeal
Model Form E	Request to Join an Existing Group Appeal: Direct Appeal from Final Determination
Model Form F	Proposed Joint Scheduling Order
Model Form G	Schedule of Providers in Group

Individual Appeals

The new rules require providers to be much more detailed in filing their appeal requests than they have in the past. First, Model Form A must be completed; the provider must attach all relevant documentation supporting the appeal request, including a concise statement of the issue[s] contested. Further, the appeal request must describe the adjustment[s] by number, why it [they] is [are] incorrect, and must state the provider's theory of the correct accounting /reimbursement methodology and why the provider's position has merit. However, if the provider does not have access to the underlying information to determine whether the intermediary's position is incorrect, it should explain that fact in detail to the Board.⁷

If the contested issue(s) has multiple components such as disproportionate share (DSH) scenarios, each contested component must be appealed separately and described in detail, as explained above.⁸ Providers that do not specifically identify all the components of an issue risk the entire appeal's dismissal.⁹ If the provider desires to add a new issue to a pending appeal's, it must timely file a completed Model C Form with the Board and attach all supporting information to justify the jurisdictional and procedural aspects of the new issue. However, the time period to add issues to a pending appeal has been reduced to 240 days after receipt of the Notice of Program Reimbursement (NPR) or other final determination.¹⁰

Moreover, the provider must forward any documentation it deems necessary to meet the PRRB's jurisdictional requirements.¹¹ Non-compliance with these requirements risks dismissal of the appeal. The provider's owner/officer or representative must certify that there is no other provider that is related to the attesting provider by common ownership or common control that has filed a similar request for appeal for the same fiscal year. Moreover, pursuant to new case law, the provider must properly document all disputed items in the cost report or risk False Claims Act liability.¹²

Group Appeals

The Board has made significant changes in the filing of a group appeal request. The PRRB has long distinguished between Mandatory Group Appeals and Optional Group Appeals, and mandated that the two types of group appeals be maintained separately. By definition, both types must involve a single common question of fact or interpretation of law, regulation, or policy in order for multiple provider requests to be consolidated into a group appeal.¹³ Practically speaking, if a chain has a number of contested, but shared common issues of law or fact, the appeals may be consolidated, but each is given a separate provider number, even though they can be argued concurrently if that is not too administratively burdensome for the Board.

Mandatory Group Appeals include providers that are commonly owned or controlled by an entity/themselves (Related Parties) and that include a common issue in the same calendar year (a Common Issue Related Party or CIRP appeal).¹⁴ Conversely, an Optional Group Appeal includes two or more non-related providers that share a common issue of law of fact. The providers

or their representative must file Model Form B with the Board to initiate the group appeal, Form D to transfer an issue to a group appeal, or Form E to appeal an issue directly to a group appeal. Similar to an individual appeal, the group representative must forward all necessary documentation to the Board.¹⁵ Each provider must attach an Authorization of Representation signed by an owner or officer of the entity and on its letterhead.¹⁶ Related providers may no longer submit one letter of representation for the entire chain organization; each provider in the group must transmit a letter of representation (on its individual letterhead) to the Board. Concurrently, the representative has to advise the Board who is initially in the group by providing a complicated schedule of included providers to the Board.

These new rules have revised the dates various filings must be received by the Board. For group appeals, the providers' preliminary position paper(s) are now due eight months after filing the appeal, significantly shortening the fourteen months that group position papers were due. Representatives for optional groups will have twelve months from the time the group was formed to notify the Board that the group is complete.¹⁷ For mandatory groups, the PRRB will determine that the group is complete upon submission of written notice from the group representative.¹⁸

Deadlines Board Standard Schedule	
Sixty days from the appeal filing deadline (240 days after final determination issuance)	Deadline to add issue to pending appeal
Eight months after filing	Provider's preliminary position paper—all arguments and evidence included
Twelve months after filing	FI responsive preliminary position paper—all arguments and evidence, and identify additional evidence needed from provider
Fifteen months after filing	Provider's rebuttal and additional evidence identified by FI
As provided in regulations and Board rules	Discovery, subpoenas
Ninety days prior to hearing	Provider's final position paper due
Sixty days prior to hearing	FI responsive position paper due
Thirty days prior to hearing	Provider's rebuttal position paper due Witness list and "experts" reports
Up to date of hearing	Revised or supplemental position papers—only to further narrow case or issue (Rule 27.3)

Preliminary Position Papers v. Joint Scheduling Order (JSO)

With the implementation of the Board's new rules, the parties are required to identify all issues well in advance of the preliminary position paper due date. This is a significant change in PRRB practice, because prior to the new rules, preliminary position papers were not expected to present fully developed positions, including comprehensive analysis. Preliminary position papers from the provider are due eight months after the filing of its appeal request; the intermediary has twelve months after the request for appeal is filed to file its fully developed submission; fifteen months after the filing of the appeal, the provider's detailed response/rebuttal to the intermediary paper must be filed.

The provider's preliminary position paper must include a discussion of the material facts that supports the party's claim for each issue; it must identify the controlling authorities supporting that position; and it must provide a factual/legal conclusion as to why the provider's position is correct. After the intermediary submits its preliminary position paper, the provider must respond within three months, addressing or rebutting all the arguments not previously addressed and attaching all the documentation not previously furnished that are responsive to the intermediary's arguments.¹⁹

The new rules introduced a major option or fork in the road in the PRRB's pre-hearing procedures. The parties can either follow a standard timeline of when their position papers are due, or the provider and intermediary may jointly agree to establish filing deadlines via a Joint Scheduling Order (JSO) that sets all pre-hearing and hearing dates. Final position paper due dates will be scheduled based on the date of hearing. The provider's final position paper and all exhibits are due at the Board at least ninety days before the hearing.²⁰

The proposed JSO contains five elements.²¹ It must, following Model Form F, identify all issues that are totally resolved and conditionally resolved and describe the condition upon which the resolution is based, and also identify the unresolved issues. Moreover, the JSO must identify the documentation already exchanged and establish a detailed time/schedule if the parties expect to require discovery or a voluntary exchange and analysis of data.

The Board must approve the signed JSO, and once approved, the parties can only modify the JSO's deadlines by a signed written agreement. Virtually all deadlines will be controlled by the JSO. If the parties do not follow the agreed upon dates, the PRRB may invoke a number of sanctions against either or both parties, including dismissal of the case.²² Given pressure on the Board to reduce its current inventory, one can expect that the Board will often exercise its discretionary power to dismiss appeals that do not strictly comply with the agreed-upon dates.

It is possible for the parties to propose a JSO after they have each filed preliminary position papers. If that scenario occurs, the JSO will supersede the rules establishing other discovery and the deadlines for documentation exchange. However, the Board will not approve a JSO if it appears it was filed merely to delay the hearing.



Final Position Papers

The PRRB has greatly narrowed the requirements of what it deems an acceptable final position paper.²³ Under the new rules, the Board mandates that the final position paper should be a refinement of the issues discussed in the preliminary position paper. Moreover, unlike previous PRRB practice, it is now virtually impossible for the parties to designate the relabeled preliminary position paper as the final position paper. The final position paper should address the remaining issues in the appeal, including the new issues, and contain—at a minimum—the identification of each issue, its reimbursement impact, the procedural history of the dispute, and a statement from each party that the facts are either undisputed, or for each material disputed fact, the evidence that the party asserts justifies its version of the facts. The paper must be accompanied by all supporting exhibits and page references. Each party must certify that it made a thorough explanation of the other party's position and include a statement as to why the Medicare authorities do not support the other party's analysis. The Board directs that revised or supplemental position paper should not present new positions, arguments, or evidence. The Board may, upon objection of the other party, exclude such arguments or evidence from consideration.

The provider's officers or its representative are now required to explain the merits of its position contemporaneously with the filing of the appeal or soon thereafter. Those providers that have no interest in actively prosecuting the appeal from the start (e.g., some providers that have joined a group appeal on a contingency basis with no real stake in the appeal unless the group prevails) will be surprised when many of those appeals are dismissed very early in the process. Moreover, many consulting firms that join related or non-related participants in group appeals will be required to categorize those providers that are CIRP participants from those that are not.

Historically, it was common practice for providers or their consultants to reopen cost reports for the same fiscal year multiple times; each amended NPR presented opportunities to file new appeals on different issues. That tactic is going to be much more closely scrutinized by the Board because a provider only has sixty additional days after filing an appeal to add new issues to the appeal. Under the Obama Administration, it is expected that

CMS will direct its intermediaries not to grant reopenings of cost reports with nearly the frequency that providers have been permitted to reopen cost reports in the past.

For factual disputes and those appeals containing purely legal issues, the process will run quite smoothly. However, it would run even better if the Board would routinely grant expedited judicial review (EJR) for purely legal issues and permit those cases to be quickly and routinely removed to federal district court. In general, that has not happened. Usually, the Board does not deem an appeal an EJR appeal, regardless of whether it is clear it is a legal issue beyond the Board's jurisdiction. When that occurs, the provider usually has to exhaust its administrative remedies by participating in an administrative hearing, incurring a two-year delay or longer before the provider has its day in court.

Because the new rules require that deadlines be strictly adhered to, a provider that appeals an issue(s) should isolate and begin preparing documentation supporting the appeal request subsequent to the exit conference, prior to the issuance of the final determination. If there is any doubt that the provider will be able to meet the Board's filing deadlines, the provider should explore the possibility of entering a JSO with its intermediary. A JSO will provide much more flexibility and time in the pursuit of an appeal than the other alternative.

The new rules favor providers that are familiar with the PRRB process, or those new to the appeal process that take the time to understand the new Board rules' ramifications and strictly adhere to the Board timetables and procedures. More than ever, if providers are going to succeed in the appeal process, they are going to have to heed the advice of experienced cost-report preparers, consultants, and attorneys about the merits of the arguments, the procedures of claiming items, and the deadlines that must be followed.

The Losers

At the other end of the spectrum, the new rules will have an impact on the disorganized and/or less experienced provider that exhibits one or more of the following characteristics:

- a. Those that procrastinate or do not focus on the appeal;
- b. Providers that co-mingle CIRP group appeals with optional group appeals;
- c. Providers that attempt to add issues to an appeal beyond 240 days after the last final determination, assuming that they have in fact filed an appeal within 180 days after that final determination;
- d. Providers that do not enter into JSOs with their intermediaries;
- e. Providers that require extensive discovery from CMS and/or from the intermediary because the appeals are complicated and CMS/the intermediary has the needed documentation;
- f. Decentralized Chain Organizations;
- g. In addition, all providers will potentially "lose" by the limitations imposed under the new discovery rules. Conversely,

the intermediaries will benefit from the tougher discovery standards and the fact that the Department of Health and Human Services (HHS) will not compel evidence or testimony from HHS, CMS, or intermediary employees.

Discovery

The Board's new discovery procedures essentially deprive providers of many discovery rights that have been standard, accepted practices at the PRRB for more than thirty years. The discovery rules could potentially create losers out of all providers.

By the time the Board became operational in August 1975, the underlying appeal procedures mandated that the Board must "inquire fully into all matters at issue and receive into evidence the testimony of witness and documents which are relevant and material to such matters."²⁴ Until late last fall, the regulations provided for pre-hearing discovery of relevant and material evidence; authorized the Board to call HHS/CMS/intermediary witnesses for testimony at the hearing, even though HHS and CMS have always been non-parties to a PRRB hearing; and provided that the Board can issue subpoenas to compel testimony—even of government employees.²⁵

In 2004, CMS issued proposed regulations, addressing the PRRB appeals.²⁶ The agency advocated changing many of the rules regarding discovery, including its timing, methodology, and which persons or entities are required to respond to discovery requests. Before 2004, if a provider could convince the Board of the relevance of the testimony, the PRRB would subpoena individuals from CMS or HHS, and other knowledgeable witnesses.

The proposed 2004 rule acknowledged that it would be unfair to deny a provider access to relevant and material evidence in the possession or control of CMS; thus, CMS proposed that non-parties be included within the scope of Board discovery procedures.²⁷

However, the 2008 regulations are radically different from CMS' 2004 comments. Pursuant to the new regulations, amended several times subsequent to August 18, 2008, the PRRB is precluded from issuing a subpoena to CMS or to the HHS Secretary. Moreover, the Board cannot command discovery from CMS/HHS.²⁸ The new regulations indicate that it is CMS' position that the obligation to respond to discovery requests and subpoenas is too much of a burden on the agency, and CMS will

not permit discovery of any employee, unless it promotes the objectives of HHS (the Department).²⁹ In September 2008, CMS amended the definition of "employee" in the Touhey regulations to include Medicare program contactors.³⁰

In implementing this radical change of procedure, the PRRB has indicated that the parties are expected to voluntarily exchange documents relevant to the dispute. However, under the new rules discovery requests are not filed with the PRRB, unless there is a discovery dispute.³¹ Initial written discovery requests must be filed with the person from whom discovery is requested and upon the opposing party; those requests must include a signed certificate of service indicating the date that the request was served, as well as the identity and address of each individual receiving a copy of the request.

Discovery requests are governed either by the timelines set forth in 42 C.F.R. § 405.1853 or in the approved JSO. Parties have a right to file a Motion to Compel Discovery or for protective orders with the PRRB, but generally the current PRRB tends to

disfavor provider-initiated discovery requests. As with the hearing itself, the burden of proof is almost always on the provider to show the necessity of the requested material and, after September 2008, that the request promotes the HHS objectives.

Discovery responses may be designated as an exhibit or read into the record at the hearing.

The option of requesting and obtaining information through the Freedom of Information Act (FOIA)³² is still theoretically available, and the Obama Administration has proposed to expedite FOIA answers as well as to provide more transparency in the agency decision-making process.

The purpose of FOIA requires that a federal agency must disclose information to any person that requests it. However, federal agencies have generally been extremely slow in responding to FOIA requests, and practically speaking, agencies do not often provide all the documentation they possess—if they provide anything at all. CMS has been no exception to this pattern, and despite the Obama Administration's intentions, Board practitioners will not see the agency turning to full disclosure of information pursuant to a FOIA request for quite some time. Accordingly, as a result of the new discovery rules and CMS' prior pattern of less-than-full disclosure, providers may find themselves in situations in which an incorrect payment determination has been made, but the providers are unable to obtain the documentation they collectively need to correct that wrong.



How to Prosper Under the New Rules

Upon being retained, the advocate should quickly analyze the nature of the case. Will it be settled—as 95% of the cases are—or will it be argued to the Board? Two-thirds of the cases that are argued eventually land in federal court. Not surprisingly, many factual disputes are settled. Conversely, cases involving a great deal of Medicare dollars, and those involving esoteric and not-so-esoteric interpretations of Medicare law or policy (e.g. compound DSH cases) are almost certain to travel to federal court because even if the provider prevails at the PRRB, the CMS Administrator will often reverse.

Upon being hired, the provider's advocate must be succinct and reasonable in communications with the intermediary and the Board, and scrupulously follow all the rules. Deadlines must be followed strictly. Oftentimes the fiscal intermediary will not meaningfully answer discovery, no matter how hard the advocate tries to obtain substantive responses. Thus, the advocate must plan on presenting as much of his or her case without the intermediary's/CMS' help or anticipated evidence. The PRRB staff is not constructed to monitor and police minute motion practice.

While the PRRB encourages the parties to enter into stipulations prior to the actual hearing itself, the provider's advocate has to be especially careful of the proposed stipulations' wording. Intermediaries often attempt to have the provider stipulate away key facts and reasonable interpretations of key portions of the Medicare pronouncements. Because CMS is the real party in interest at Board hearings, the government has argued that stipulations the intermediary has entered into are not binding in judicial review.

The advocate can expect that, in many cases, the intermediary will not submit to cross-examination, even though the intermediary's advocate argues the case and cross-examines the provider's witnesses. This type of practice was not permitted by earlier PRRBs because consistent with the congressional intent of the bill³³ that created the PRRB, there was to be "a true windowing and shifting of the facts and the law." All the provider's advocate can do is repeatedly remind the Board of the provider's search for evidence and assure that the record contains numerous references to the rule of adverse inference, which states that the facts should be construed against the party (the intermediary, here) that does not submit to cross-examination.

Conclusion

Who really are the winners and losers under the new PRRB rules? All providers have something to lose if they are the subject of incorrect payment determinations by CMS' intermediaries and they cannot obtain the necessary evidence under the revised discovery rules to show otherwise. Simply because CMS claims that responding to discovery requests is too burdensome³⁴ should not be enough to justify the negative effects that the absence of meaningful discovery could have on providers' attempts to reclaim their reimbursement funds. These new discovery rules will undoubtedly be the subject of federal litigation after their impact remains unresolved. In fact, this scenario may require legislative intervention.

The most important lesson to be learned by a provider is that in order to be successful under the new rules governing an appeal at the PRRB and beyond, the provider must be extremely organized and remain in control of the appeals process. Despite some perceptions otherwise, a Board hearing is truly an adversarial proceeding. It is the provider's duty to assure that the administrative record contains all available evidence to support its case, as well as numerous references, if applicable, to the fact that the intermediary/CMS failed to produce relevant evidence repeatedly requested by the provider. If the provider fails to do so, it risks the dismissal of its appeal in addition to losing on the merits.

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- 1 73 Fed. Reg. 30190 (May 23, 2008).
 - 2 The instructions are available at www.cms.hhs.gov/PRRBReview/02_PRRB_Instructions.asp#TopOfPage.
 - 3 See Social Security Act § 1878.
 - 4 *Id.*
 - 5 73 Fed. Reg. 30190 (May 23, 2008).
 - 6 PRRB instructions, at 45-48.
 - 7 Rule 6, PRRB Instructions, at 4-5.
 - 8 Rule 8, PRRB Instructions, at 6-7.
 - 9 Rule 8 and 42 C.F.R. § 405.1835.
 - 10 42 C.F.R. § 405.1835(c).
 - 11 42 C.F.R. § 405.1835(b)(3).
 - 12 31 U.S.C. § 3729; *United States v. Bourseau*, 531 F.3d 1159, (9th Cir. 2008).
 - 13 Rule 12, PRRB Instructions, at 8-9.
 - 14 Rule 13, PRRB Instructions at 10.
 - 15 PRRB instructions, at 48-56.
 - 16 Rule 12.4, PRRB Instructions, at 9.
 - 17 Rule 19.1, PRRB Instructions, at 11.
 - 18 Rule 19.2, PRRB Instructions, at 12.
 - 19 Rule 25, PRRB Instructions, at 20.
 - 20 Rule 23.2, PRRB Instructions, at 18.
 - 21 Rule 24.1, PRRB Instructions, at 19.
 - 22 Rule 24.4, PRRB Instructions, at 20.
 - 23 Rule 27, PRRB Instructions, at 23.
 - 24 42 C.F.R. § 40.1835(b)(4)(i), PRRB Instructions, at 47.
 - 25 *Id.* and 42 C.F.R. § 405.1857.
 - 26 69 Fed. Reg. 35716 (June 25, 2004).
 - 27 *Id.*
 - 28 73 Fed. Reg. 30190 (May 23, 2008).
 - 29 73 Fed. Reg. at 30215-16, 30218, 30220.
 - 30 *Id.* at 30222-23. The Touhey regulations in Part 2 of Title 45 of the Code of Federal Regulations, discuss requests for production of documents from HHS in litigation in which the United States, as a federal agency, is a party. Pursuant to the Touhey regulations, CMS need not produce requested documents or testimony from a current "employee," unless CMS determines that it would promote the "objectives of the Department."
 - 31 Rule 26.1, PRRB Instructions, at 22.
 - 32 5 U.S.C. § 552.
 - 33 Pub. L. No. 92-603 § 243
 - 34 73 Fed. Reg. at 30215-16, 30218, 30220.
 - 35 The authors are indebted to J. Harold Richards and Christopher L. Keogh of King & Spalding LLC who first explained the ramifications of CMS' new regulations in the November 2008 edition of Dennis Barry's *Reimbursement Advisor*.