PUBLICATION

CMS Changes to Cost Report and Appeal Rules Are Now in Effect [Ober|Kaler]

2016

As part of the Outpatient Prospective Payment System (OPPS) final rule published in the Federal Register on November 13, 2015, CMS made noteworthy changes to the Medicare cost report and appeal rules. *See* 80 Fed. Reg. 70298, 70551-70580, 70597-70604. As we discussed in a June 2, 2014 *Payment Matters* article, CMS originally proposed a version of these changes as part of the FY 2015 IPPS/LTCH PPS proposed rule. In the final rule for that year, however, CMS did not "finalize" its proposals and instead stated that it wished to study the matter further. Now, however, CMS has largely adopted its prior proposal.

In essence, what CMS has done is remove from the current appeals rules the jurisdictional requirement that a provider must have "claimed or protested" an item as a condition of filing an appeal, and has, instead, made that requirement a substantive cost report requirement. More specifically, in 2008, CMS had amended 42 C.F.R. § 405.1811(a)(1) and 42 C.F.R. § 405.1835(a)(1) to require, as a condition to filing an appeal, that the provider have either claimed an item in its cost report when seeking reimbursement or included that item as a protested amount when filing its cost report. Now, however, in the OPPS final rule, CMS has moved this requirement from the appeal section of the regulations to the cost reporting section at 42 C.F.R. § 413.24(j).

The new regulations contain language of which providers should take note. First, in order to potentially qualify for reimbursement for a "specific item," the provider must claim the full reimbursement amount or self-disallow that specific item in its cost report. Particularly as it relates to self-disallowances, the provider must include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line or lines of the cost report and attach a separate worksheet to the provider's cost report for each self-disallowed item. The provider must explain why it self-disallowed each specific item and describe how the provider calculated the estimated reimbursement amount for each specific self-disallowed item. 42 C.F.R. § 413.24(j)(2).

Among its changes in the final rule, CMS also modified its PRRB appeal regulations to specify that for "each specific item under appeal," the provider must explain in its hearing request why, and describe how, the provider is dissatisfied with the specific aspects of the contractor's determination. 42 C.F.R. § 405.1835. If the provider self-disallows an item, the hearing request must explain the "nature and amount of each self-disallowed item," the reimbursement sought for the item, and why the provider self-disallowed the cost instead of claiming reimbursement for the item.

Finally, in its Federal Register discussions, CMS recognized that there may be occasional instances in which providers lack the information necessary to make specific cost report claims. More specifically, in the context of claiming Medicaid eligible days as part of the Medicare DSH calculation, providers may lack state-verified data to support their claims. CMS will instruct contractors to accept an amended cost report submitted within a 12-month period after the hospital's cost report due date to allow submission of this revised eligible-days data. 80 Fed. Reg. at 70560. As to other issues, however, CMS believes that providers should generally be able to file their claims within the normal cost report filing time limits. If providers contend that they do not have the required data within that time or otherwise believe that claims should be amended, CMS allows, but is not requiring, contractors to accept amended cost reports or reopenings. 80 Fed. Reg. at 70561.

Ober|Kaler's Comments

In theory, the new changes contained in the OPPS final rule are effective January 1, 2016. In practice, however, much of what is contained in the new rules has been reflected in contractor and PRRB actions for the past several years. Contractors and the PRRB have required greater and greater specificity from providers when reviewing cost report claims, and have demanded that "separate" issues be individually identified and claimed. The problem has been, and will continue to be, that what a provider may view as a "single" claim, the contractor may view as multiple claims, each of which must be identified separately and described with particularity. This has been particularly evident in the areas of the disproportionate share hospital adjustment, direct graduate medical education and indirect medical education reimbursement. Accordingly, providers are well advised to be as particular as possible in identifying each element of a reimbursement claim on their cost reports, especially when self-disallowing costs that they anticipate appealing, and to describe each such element with considerable detail.