CMS-1727-P-1 **Medicare Program; Provider Reimbursement Determinations and Appeals**

Submitter : **Mrs. Linda Stapley** **Date & Time:** **07/08/2004**

Organization : **None**

Category : **Other Health Care Provider**

Issue Areas/Comments

Issues 1-10

BACKGROUND

I don't believe the originators of Medicare/Medicaid ever intended for physicians in any area to stop providing medical care to Medicare/Medicaid patients, but that is what has happened in my northeastern Nevada town. However, rural areas all over the country are being affected too. Elderly, sick patients in my area now have to travel miles out of town or to another state in order to receive even basic medical care. Our primary care doctors and OB/GYN doctors claim they cannot subsidize Medicare/Medicaid any longer because of the low reimbursement rates, compounded by extremely high medical malpractice insurance hikes. Our hospital and the Carlin Community Clinic are overwhelmed by the influx of patients seeking help. The economic future of our town is at risk because of the lack of medical care available to newcomers and new Medicare/Medicaid patients. I understand that doctors have made some very difficult decisions in denying care to the poor and elderly, but this kind of discrimination is deadly to rural areas like ours. They obviously are not receiving any incentives to extend care to any but the paying patients. Physicians everywhere, but especially in rural areas, need to pay less for medical malpractice insurance, receive higher reimbursements, and perhaps even be allowed tax rebates for serving Medicare/Medicaid patients. Congress must pass restrictions on deep pocket lawsuits, help our physicians help us, and put and end to discrimination of society's must vulnerable citizens. Something needs to be done, and soon, so that EVERYONE in America has access to quality medical care.
Thank you.

Submitter : Mr. Richard WILSON **Date & Time:** 08/03/2004 07:08:14

Organization : APGUARD MEDICAL

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

I am very concerned about what cms is doing to our homecare services to the elderly. I am a dme/respiratory provider and have been servicing patients for 31 years. The current talk about rate cuts and competitive bidding WILL elimanate providers and SERVICES. CMS needs to match apples to apples and that is NOT being done. The current talk about cost plus 6% for Respiratory medication does not even cover the providers cost of doing that service. We for one will discontinue providing to medicare patients. Not becouse we want to CMS just does not want to pay for the product is the bottom line. CMS needs to start looking at the DME/Respiratoy providers as a asset not a libility. We are keeping patients out of hospitals and long term care centers. The cost of 1 month of home oxygen including ALL supplies and services is less the 1 ER visit or 1 day in a hospital. CMS needs to be putting revenue into homecare not strangeling the service realy saving the program money at the end of the day. As CMS reduces part B payments it will increase part A expences. I pray that someone is realy paying attention to what these cuts are are going to do to a industry that has a direct impact on patients standard of living.
Richard Wilson
818-731-8514

Submitter : Mrs. Lisa Roberson **Date & Time:** 08/06/2004 06:08:15

Organization : Mrs. Lisa Roberson

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

I have just recently started with a company that provides therapy services in SNF's and ALF's. I have come to understand that Medicare B clients can only be seen 1:1. Whereas, Medicare A clients can have 100% 1:1 or up to 25% of their weekly therapy provided to them in the form of group therapy as deemed appropriate and necessary for goal achievement. The profession of occupational therapy has roots deeply ingrained in the therapeutic use of groups for crafts, coping skills groups, energy conservation groups, retraining clients in cooking, ordering in a restaurant, exercise, etc. in order to enhance and improve the quality of life in many areas - cognitive, social/emotional, spiritual and physical. The elderly in SNF's and ALF's can have very high incidences of depression and very limited social interaction due to their multiple medical problems. I feel strongly that Medicare B should reconsider reimbursement for Group Therapy so that these clients can receive the same benefits and Medicare A clients. Simply, there are times when group therapy is the best choice and can provide the most for functional outcomes - higher levels of independence in activities of daily living.

Submitter : Dr. Joseph Torchia **Date & Time:** 08/06/2004 12:08:00

Organization : Holy Spirit Hospital

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

The DRG for heart failure does not allow for a concurrent condition modifier (cc). A patient who is admitted to the hospital with heart failure, has an uncomplicated course and is discharged home has the same DRG and reimbursement to the hospital as a patient who comes into the hospital in heart failure, develops respiratory failure and requires mechanical ventilation. The intensity of service is much different in these cases. This would not apply to patients who have a primary pulmonary condition leading to respiratory failure and mechanical ventilation. There is a separate DRG for this. Thank you for your consideration.

Submitter : Mr. Brian Hortz **Date & Time:** 08/10/2004 01:08:46

Organization : Denison University

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am writing to express my concern over the recent proposal that would limit providers of incident to services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

CMS-1727-P-5-Attach-1.doc

Brian V. Hortz, MS, ATC
Assistant Professor / Head Athletic Trainer
Denison University
200 Livingston Drive.
Granville, OH 43023

August 10, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

* "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals whom the physician deems knowledgeable and trained in the protocols to be administered. As an athletic trainer that is licensed and educated to provide these services, I feel it should be the physician's choice to decide what qualified therapy providers should provide care to their patients based upon the needs of their practice, medical subspecialty and individual patient.

*
There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

* In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

* This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

* Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

* Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.

* Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor’s or master’s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

* To allow only physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

* CMS, in proposing this change, offers no evidence that there is a problem with how “incident to” services are currently being offered. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services. In fact, a case could be made that there is an anti-trust thrust to this measure. It appears that this is an attempt to be a restraint of an athletic trainers access to the free market of third party

reimbursement.

* CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

* Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

* Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

* These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Brian V. Hortz

Submitter : **Date & Time:** 08/11/2004 05:08:32

Organization :

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012
Re: Therapy ? Incident To

CMS-1727-P-6-Attach-1.doc

Attach # 6

August 11, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

According to 'incident to', a physician has the right to delegate services to anyone they deem appropriate to provide such services. I agree that these providers should have a formal, specified education. But, eliminating certified (and in most states licensed) athletic trainers will do a disservice to the Medicare population. Physical therapists are not the only profession with an education and an understanding of the human body, its systems and associated techniques to expedite the healing process.

As a director of a sports medicine program I supervise 19 physical therapist and 14 athletic trainers. Both disciplines have similar basic knowledge and most times they complement each other when treating patients. The difference I notice among each profession is inter-discipline; where they received their education is much more important than the initials after their names. I propose that we work to increase our educational standards, not fight to eliminate trained professional from healthcare.

I am tired of this turf battle over who can treat what population and in what setting. I would trust any of our physical therapists with treating my young, athletic son and I would trust any of our athletic trainers with treating my old, frail grandmother. To draw a line in the sand between disciplines is counter-productive to our healthcare system. Instead, Medicare needs to focus on how healthcare providers can work together to decrease the costs of healthcare.

Sincerely,

Ben Bonney
Director, Sports Medicine
Middletown Regional Hospital

Submitter : Mr. Philip Taylor **Date & Time:** 08/14/2004 12:08:25

Organization : Nata

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Via Electronic Mail -- http://www.cms.hhs.gov/regulations/ecomments

Philip Taylor
Shifting Sands Medical Association
123 Main Street
Springfield, MO 56789

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy - Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

? ?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

? There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY ?incident to? service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

? In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

? This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

? Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

? Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.

? Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a masters degree.

Submitter : Mr. Michael Redmond **Date & Time:** 08/17/2004 12:08:00

Organization : United Government Services

Category : Private Industry

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1727-P-8-Attach-1.doc

August 17, 2004

Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1727-P
P.O. Box 8017
Baltimore, MD 2124-8017

Re: Medicare Program: Provider Reimbursement Determinations and Appeals; Proposed Rules

Dear Sir and/or Madam:

The following are UGS' comments pertaining to the Medicare Program: Provider Reimbursement Determination and Appeals; Proposed Rules. All comments relate to Section II, and appropriate page references are included.

1. Calculating Time Periods

Page 35718 (Section II. B):

Excellent clarification. This will eliminate confusion as to when to determine the date of submission of material. This will identify precise time periods and deadlines. Another good point under this category is the revision to the current definition of "date of receipt". The 5-day presumption would give an accurate determination of the date of receipt and alleviate the confusion surrounding the 180-day period for requesting a Board appeal.

2. Provider Hearing Rights (Section II. D)

2a. Contents of Hearing Request (Section II, D.4)

Page 35723

Clarification was necessary since Providers were adding issues to a Revised NPR that were not within the scope of the Revised NPR.

2b. Contents of Hearing Request (Section II. D.4)

Page 35724

The following is confusing – "The hearing request would no longer need to include documents necessary to support the merits of the provider's position on a specific reimbursement matter because the reviewing entity must make a preliminary finding of its jurisdiction over each matter at issue before it considers the merits of a particular issue." In order to determine the merits and preliminary findings of its jurisdiction, the Intermediary needs the necessary documents to support the merits of the provider's position.

2c. Adding Issues to Existing Hearing Request (Section II. D.5)
Page 35724

1. Requiring all issues to be identified within 60 days would really add huge efficiencies to the process. If the intermediary works on a resolution, they could implement early on. Also, this would no longer encourage providers to keep appeals open simply as placeholders so they can add issues at some future time in case something comes up. Intermediaries have had appeals where a resolution was clearly possible, but the provider/consultant chose not cooperate, as they really did not want to close the appeal yet. There have been cases where the intermediary agreed to a resolution, but when it was time for the case closure, the appeal was reinstated so new issues could be added. This will be in the best interest of all parties, but will require the work that in the past was pushed off into the future many years, to be done early on resulting in a much more streamlined process, albeit a much more intensive process early on. This proposal is critical to proper case management for all parties.

2. Another recommendation is that there be no additional time beyond the 180 days. The Providers have 180 days to determine what issues are not agreed to and file an appeal on the specific issues. CMS should consider if there should be no new issues allowed after the 180 days and then the 60 days could be eliminated.

2d. Hearing Notice not Precise (Section II. D.5)
Page 35724

What happens when the appeal is very generic in it's issue? For instance, what if an appeal simply notes the issue as "DSH", then as the parties digs into the details, the provider discusses and adds many issues as they come up in reviewing DSH such as SSI, paid days, partially eligible, dual eligible, HMO, labor room days, etc. In other words, how specific does the issue have to be when appealed. And if the appeal is too general, what are the actions to be taken and by whom. At what point do we mandate they clarify exactly what they are appealing and what type of challenge should be made where there is disagreement over exactly when this line is crossed. Without clarification here, general issues could be appealed in the 180 days (or 60 additional days). If the appeal is then "clarified" after this time period to bring in various previously unknown issues related to the issue, how would this be addressed?

3. Provider Request for Good Cause Extension (Section II. E)
Page 35725

Concern – "To extend the appeals period provided that the provider's good cause extension request is received by the Board within a reasonable time after the expiration of the 180-day period (but in no circumstances more than three years after the date of the Intermediary determination)."

How does "reasonable time" equate to "no more than three years after the date of the Intermediary determination."?

4. Parties to a Board Hearing (Section II. L)
Page 35732 – Mechanism by which CMS may be included in the hearing process

Excellent addition to the rules. It gives the Intermediary an excellent tool to designate a representative from CMS to defend its position.

5. Quorum Requirements (Section II. M)

Page 35732 – Requests for Full Quorum?

What if one party really wants the full Board to hear the case? Will the Board take a request from either the Intermediary or the Provider that it be heard by a full quorum? Will both provider and intermediary be given the same weight in their requests? Is there a request mechanism going to be developed or is once the decision made, it is final? As long as the 60 day requirement for appeals is left, position papers will be available to decide from. However, if the 60 days to add issues is not kept, the written position paper needs to include everything, as testimony may not be heard, only read by the other members and if issues are allowed to be added as they are now, intermediaries will be scrambling to issue supplemental position papers up to and on the day of the hearing.

6. Board Proceedings Prior To Hearing (Section II. N)

Page 35733 – Discovery

6a. What if documentation is received after the 45 days? Will this be considered by the PRRB in the hearing? If so, then this deadline means little as timely discovery from the intermediary depends on what they have to review and request from.

6b. What if documentation is requested and received in the 45 days, but additional backup to test is then required by the intermediary to supplement and test the initial documentation, but the 45 days is now expired?

6c. Further clarification is needed between what is due within 45 days vs. what is due within 90 days

7. Reopening Procedures (Section II. V.1)

7a. Page 35740 & 35764 – 3 year Reopening

In the comments, it notes that the providers request must be received within the 3 years and the intermediary can reopen it. However, 405.1885(b)(3) still states that "No Secretary or intermediary determination... may be reopened after the 3-year period in paragraphs (b)(1) and (b)(2) of this section, except as follows..." and at no point does it specify that the intermediary has the authority to reopen the cost report after the 3 years, as long as the provider submitted it to the intermediary within the 3 years. The updated regulations do not match the comments in the FR on page 35740 and contradict each other.

In addition to the above, it also comments that “when the request for reopening is received late in the 3-year period, the issuance of a reopening notice does not have to occur before the expiration of 3 years.” This also contradicts the regulations requiring that no cost report may be reopened after the 3-year period. The clear issue is that only the intermediary can reopen and the decision to do so is at their full discretion.

In summary, how can the intermediary reopen after the 3 years has expired, if they are not allowed to reopen in any case where the 3 years has expired?

7b. Page 35741 – Reopening Issue under Appeal

States, "In the proposed paragraph (C)(3), we would state that the intermediary may reopen, on its own motion or on request, a determination that is currently pending on appeal before the Board or the Administrator." The current writing of the draft rules on Reopening items under appeal allows for the AR process to be unnecessarily bypassed. This draft of the reopening rules is written so intermediaries would simply send a reopening letter on an issue that is under appeal, the provider would drop the issue. By doing this, the entire AR process would be circumvented (and BCBSA would have no involvement or control over this, as required as prime contractor.) This writing could lead to confusion, misapplication of the appeal vs. reopening process, and possible misuse of the reopening and appeal process. This completely blurs the line between an administrative resolution and a reopening. Exactly when would each be used and why would it be different?

Suggest Change to Clarify: If the issue is or was under appeal, the issue must be settled as an Administrative resolution following the protocols in the appeal process. A reopening should not be issued without the proper approval process for providers who have filed appeals and the reopening process should not be used to circumvent the appeal process by either party.

8. <u>Not Addressed in the Proposal – Requests for Additional Clarifications</u>

There should be a outside deadline for case decisions to be made by the PRRB from the date of the live hearing, the date of the agreement for an "on the record" hearing, or the date a jurisdictional challenge is submitted. An outside deadline would assure all the parties that the PRRB decision would come by a certain date and continual follow-up from all parties would not be necessary and cases would not get lost "in the system" for long periods of time. We recommend the instructions include various fime frames as guidelines for the PRRB to follow to complete their task. This would definitely increase the efficiency of monitoring the cases for all parties.

Thank you for the opportunity to comment on the Provider Reimbursement Determination and Appeals: Proposed Rules.

If you have any questions, please contact George Garcia or Dick Heesen at (805) 367-0575 or 414-226-6981, respectively.

Sincerely,

Michael G. Redmond, Manager
Provider Audit Department
United Government Services, LLC

Submitter : Mr. Robert Gagnon **Date & Time:** 08/19/2004 01:08:21

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

"incident to" comment

CMS-1727-P-9-Attach-1.doc

Attach # 9

Rob Gagnon, MA, LATC, CSCS
Manchester Athletic Club
8 Atwater Avenue
Manchester-by-the-Sea, MA 01944

September 15, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy – Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

* "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

*
There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the

professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

* In many cases, the change to “incident to” services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

* This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working “incident to” the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

* Patients who would now be referred outside of the physician’s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient’s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

* Curtailing to whom the physician can delegate “incident to” procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician’s ability to provide the best possible patient care.

* Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor’s or master’s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master’s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

* To allow only physical therapists, occupational therapists, and speech and language pathologists to provide “incident to” outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate that only these practitioners may provide “incident to” outpatient therapy in physicians’ offices would improperly remove the states’ right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

* CMS, in proposing this change, offers no evidence that there is a problem that is in need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would

seek to establish themselves as the sole provider of therapy services.

* CMS does not have the statutory authority to restrict who can and cannot provide services “incident to” a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

* Independent research has demonstrated that the quality of services provided by certified athletic trainers is equal to the quality of services provided by physical therapists.

* Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. In addition, dozens of athletic trainers will be accompanying the U.S. Olympic Team to Athens, Greece this summer to provide these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

* These issues may lead to more physician practices eliminating or severely limiting the number of Medicare patients they accept.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,

Rob Gagnon, MA, LATC, CSCS

Submitter : Mr. Edward Coyle **Date & Time:** 08/20/2004 12:08:00

Organization : Mercy Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached Word document

CMS-1727-P-10-Attach-1.doc

August 20, 2004

The Honorable Dr. Mark McClellan
Administrator
Center for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1470-P; P.O. Box 8010
Baltimore, MD 21244-1850

RE: CMS-1727-P – Medicare Program; Provider Reimbursement Determinations and Appeals; Proposed Rule (69 Federal Register 35716).

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for changes to the provider reimbursement determinations and appeals, published June 25, 2004 in the Federal Register. I am the Director of Revenue and Reimbursement for Mercy Health System.

Background:
You mentioned the development of a backlog of approximately 10,000 cases before the Board, which is a factor for required changes used in much of this proposed rule. One reason for the backlog is the Supreme Court decision in the "Your Home Health" case, that the fiscal intermediary (FI) has complete discretion in reopening requests. After that decision our old hospital system instructed members that whenever filing a reopening request to also file an appeal prior to the expiration of the 180-days in case the reopening is denied. Shortly thereafter the former Director of our FI, Veritus Medicare Services, issued instructions to his staff to deny any reopening where an appeal was also filed. I have appeals that have been open for several years for issues as simple as incorrect PS&R figures used on the NPR. A quick reopening would have ended this issue for several of my appeals for multiple hospitals on the PRRB docket. Instructions to FI's not to consider the fact that an appeal has been filed in evaluating a reopening request might help alleviate some of the PRRB backlog in the future.

Provider Hearing Rights:
Section 1. Provider dissatisfaction with Medicare reimbursement, CMS mentions their "…longstanding policy that a cost report claim at variance with Medicare policy is not improper." However, mixed signals are sent, as the FI's warn if an audit adjustment is made three years in a row, you are on notice of its disallowance and will be referred for fraud & abuse investigation. The protested amount line is available for use in situations where the Provider is not in agreement with the Medicare policy, you should be holding that out as the way to assert differences of opinion with Medicare policy.

Section 5. Adding issues to original hearing request, the proposed rule would make the latest date to add an issue to an appeal twenty months after filing the cost report (12 without an NPR, 6 for PRRB appeal, and 2 for adding issues). During the outlier debate, CMS pointed out that some FI's have NPR's outstanding for over two years, as reason for the inaccurate cost-to-charge ratios. For those providers with such late original NPR's, this rule would preclude them from

appealing any audit adjustments made in the NPR. I do not disagree in principle with limiting the open-ended period for adding issues to an appeal, but such an absolute limit should be tied to the actual issuance of the NPR. Also, in light of the fact that a change of interpretation is not reason for reopening a cost report, adding an issue to an existing appeal is the only venue available to providers, therefore I believe the deadline should be extended from the proposed 60-days after the original 180-days to an additional 180-days to give the providers opportunity to learn of and evaluate potential issues. Although that gives the provider a full year after the NPR to add an issue to an appeal, it is considerably less than the three years that an NPR can be reopened.

Group Appeals:
The requirement of proposed §405.1837(b)(1) that a provider subject to the mandatory group appeal request a group appeal as the initial appeal request is not practical. Not all commonly owned hospitals are centralized or situated as such to coordinate initial appeals as a group appeal in such a way as to not miss the 180-day requirement for an individual hospital. How can CMS expect a hospital close to its 180-day appeal deadline to coordinate a group appeal with another commonly owned hospital in another state with a different FI, who does not yet have their NPR or may not be close enough to the 180-day deadline to have fully evaluated the NPR issues? Also, by requiring such coordination, CMS is limiting these commonly owned hospitals to less than the full 180-day appeal deadlines, where a single hospital can wait until the end of the 180-days to review and submit an appeal. CMS cannot treat like hospitals differently, but requiring the initial appeal of a system hospital to be a group appeal, along with all of the new filing requirements of a group appeal, is treating them differently. I could understand requiring consolidation within a certain time after the initial appeals are filed and the 180-day requirement has been met; perhaps require listing the parent corporation in the initial appeal letter to help PRRB identify hospitals under common ownership for consolidation.

Board Proceedings Prior to Hearing:
Please clarify for discovery deadline purposes that the "scheduled starting date of the Board hearing" is the specific date the hearing is on the docket, and not the anticipated month of the hearing date listed on the "key dates" letter received from the Board when the appeal is filed.

Reopening Procedures:
Please add guidance to the FI's reopening discretion that the fact that a PRRB appeal has been filed for the same issues prior to the 180-day deadline is not to be a factor in considering accepting or denying such reopening request. Our FI, Veritus Medicare Services, on order from its former Director has denied reopening requests solely on the basis that an appeal existed for that year. Reopening requests for items as simple as incorrect PS&R figures used in the NPR have been denied, adding to the PRRB backlog.

Very Truly Yours,

Edward J. Coyle
Director, Revenue & Reimbursement

Submitter : Mr. David Mocklin **Date & Time:** 08/23/2004 05:08:33

Organization : Kenner Regional Medical Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

I am writing you about the recent proposal that would limit the providers of "incident to" services in M.D. offices and clinics.

I am an ATC and also a licensed PTA and belong to both the NATA and the APTA.
For those people who need to be educated on what a certified athletic trainer is, these are highly educated professionals who must have either a B.S. or M.S. from an accredited university. These people are required to complete the same type of classes as P.T.'s. O.T.'s and speech therapists.

I should know. I attended PTA school after I had already become an ATC. My previous training as an ATC had helped me tremendously and I viewed my learning experience in PTA school as "a very good review."

I have also had the chance to work with some of the world's most elite athletes, including a world heavyweight champion in boxing and 2 members of Major League Baseball's Hall of Fame.

I beleive that ATC's who happen to be qualified to work with the most elite athletes in the world probably have the ability and certainly have the training to be utilized by physicians to provide any "incident to" service.

Submitter : Ms. Lee Crooks **Date & Time:** 08/23/2004 08:08:33

Organization : Premera Blue Cross

Category : Federal Government

Issue Areas/Comments

Issues 1-10

PROVIDER HEARING RIGHTS

Re: File Code CMS-1727-P
II.D. Provider Hearing Rights

II.D.1. discusses self-disallowance in terms of the Bethesda decision, which means that the Provider is prohibited by a Medicare policy, regulation or manual provision from making a claim in the body of the cost report. Instead the estimated reimbursement amount is filed in the protested amount on the cost report settlement page in accordance with CMS Pub. 15-2 ?115.

We are finding what we consider to be an inappropriate use of the protested amounts by some Providers. This misuse could be prevented by adding the regulatory requirement that the Provider identify the regulation, or whatever authority, it is challenging along with the other requirements at ?405.1835(b)(2) and ?405.1811(b)(2) (II.D.4. ?Contents of Hearing Request?).

Specifically, we have had three instances in the last six months where the Provider filed an estimated claim, specifically identified as related to bad debts, in the protested amounts. When the preliminary position papers were filed, the reason given for the protest treatment was lack of supporting documentation. In fact, in all three cases, there was still no basis for the claim by the time position papers were due.

This Intermediary does not consider such claims valid self-disallowance in the Bethesda sense of the term. Nor does an adjustment to remove such a ?self-disallowed? protested amount seem a sufficient basis to secure an appeal in these instances.

If the Provider had to identify the regulation it is challenging, it would become obvious that they are merely seeking more time to gather documentation and to avoid a possible reopening denial due to ?lack of documentation? under Change Request 1468 (Dec. 14, 2001) had they reported the claim in the body of the audited cost report. I doubt the Providers are actually challenging the regulations at 42 CFR ?413.20/.24 that require a claim to be documented. But if that is what they identify, the final rule should clarify that their appeal would be limited to that challenge.

Intermediaries have been granted some discretion under CR 1468 to deny reopenings when the Provider was culpable in not adequately documenting their claims that were reported not under protest, but in the cost report proper, and thus audited. Because of this, the proposed self-disallowance rules as written could actually result in more appeals, as they seem to provide a way around the audit of completely unsupported claims. We recommend adding a requirement that the regulation (or whatever) being challenged must be identified and clarifying that an appeal would be limited to that challenge. That would discourage the use of protested amounts to avoid audit.

These enhancements to the rule would, as you say on pg 35723, ?facilitate the reviewing entity?s capacity to determine compliance with our proposed self disallowance rules?.

Thanks for your consideration,

Lee Crooks, CPA
Medicare Technical and Appeals Coordinator

CMS-1727-P-12-Attach-1.doc

Submitter : Mr. Robert Poli **Date & Time:** 08/23/2004 08:08:40

Organization : Catholic Health Initiatives

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 1-10

GROUP APPEALS

H. Group Appeals (? 405.1837).

? For providers that require a ?mandatory? group appeal (common issue related party) please clarify or confirm:
o As soon as there are two providers with an NPR and the group issue, a timely (within the allowed 180-day time period of the NPRs) request for group formation should be sent to the Board.
? Note from the provider perspective this can benefit all subsequent ?group? providers as within their initial Request for Hearing they can simply appeal and transfer the issue to the group.
? Thus are not compelled to complete Position Papers on the issue.
? Can the providers and the Group Representative assume these two providers are inherently in the group?
? Thus do not require a separate (timely) notification to the Board indicating a transfer of the issue to the group.
o Once the group if formed, it is assumed the Group Representative can (still) directly add providers to the group?
? Thus unless a provider has another issue, the provider need not send a separate Request for Hearing letter to the Board.
o Per the proposed rules: Although a group is requested, there will be no Board imposed time period stipulating the ?group is complete?, the later performed only when the group representative can indicate the group is ?jurisdictionally complete?.
? Thus, there is no need for an Attachment-Schedule B?
o For the one group issue, if in order to reach the $50,000 threshold, the Board may permit years to be combined.
o There can be an instance where a group appeal issue involving a related party is through an audit adjustment (not a ?protested? or ?self-disallowed? amount).
? Thus it may not be known how many providers are impacted until there are the individual NPRs.
? E.g., many FIs do not reflect home office audit adjustments into provider cost reports; ultimately there could be only one provider impacted.

Issues 11-13

REOPENING PROCEDURES

V. Reopening Procedures (?? 405.1885 through 405.1189).

? Upon a provider timely request for a reopening:
o Within one month of receiving the provider-reopening request, the FI must in writing acknowledge (receipt) of the request.
o The provider is only required to have ?reasonable? accompanying support document.
? So that a FI cannot after the three-year period expires deny the request due to ?insufficient? support.
o The FI be given a specific (reasonable) amount of time to request additional support or render a decision.
o It is the understanding the provider must make a timely reopening request for all issues.
? Thus after the three years expiration, the provider cannot add an issue.
? Then it would only be logical and fair that upon expiration of the three-year period, unless the FI had already issued a letter of Intent to Reopen listing specific issues, the FI cannot address issues beyond the scope of the provider request.

Submitter : Mr. Terry Gouger **Date & Time:** 08/24/2004 03:08:26

Organization : Mutual of Omaha Insurance Company, Inc.

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

M. QUORUM REQUIREMENTS
The proposed rule clarifies that more than one hearing may be held simultaneously. The Board Chairman could designate one Board member to conduct a hearing. Under the proposal,it would be necessary for the Board Chairman to obtain the approval of the provider or the intermediary before he or she could assign less than a quorum to conduct a hearing. We believe that it is necessary to have at least 2 Board members present at live hearings. This is necessary to ensure that differing views/opinions/experiences/interpretations of Board members present at live hearings do not sway the outcome of Board decisions.

Issues 1-10

BOARD PROCEEDINGS PRIOR TO HEARING

It is proposed the each position paper set forth the relevant facts and arguments concerning the Board's jurisdiction over each remaining issue in the appeal, and that any supporting exhibits must accompany the position paper. The proposed requirement is intended to facilitate the Board's ability to make preliminary findings as to whether it has jurisdiction with respect to each specific matter at issue. The Board should issue jurisdictional decisions early in the appeal process. Some jurisdictional challenges by the Intermediary are over 4 years old with no Board jurisdictional decision. Time requirements for a Board jurisdictional decision on challenges should be set. There have been many instances where a hearing is held on the merits and the jurisdictional issues concurrently. If there are no time limits imposed upon the Board, we may gravitate toward delaying these decisions which creates additional, and possibly, unnecessary work for the Provider and Intermediary. Preferably, all Board jurisdictional decisions should be rendered before the Board's acknowledgement letter goes out establishing due dates for position papers and scheduling a tentative hearing month. Moreover, all Board jurisdictional decisions should be published for public viewing.

PROVIDER HEARING RIGHTS

4. CONTENTS OF HEARING REQUEST...
The proposed rule encourages an 'early focus' by the parties and the reviewing entity on the jurisdictional requirements for a hearing before the Board. The Board should also issue jurisdictional decisions early in the appeal process. Some jurisdictional challenges by the Intermediary are over 4 years old with no Board jurisdictional decision. Time requirements for a Board jurisdictional decision on challenges should be set. There have been many instances where a hearing is held on the merits and the jurisdictional issues concurrently. If there are no time limits imposed upon the Board, we may gravitate toward delaying these decisions which creates additional, and possibly, unnecessary work for the Provider and Intermediary.

5. ADDING ISSUES TO ORIGINAL HEARING REQUEST...
The proposed rule allows Providers to add issues to the hearing request during a 60-day period, commencing with the expiration of the applicable 180-day period for submitting the original hearing request under proposed section 405.1811(a)(3) and section 405.1835(a)(3). It is our belief that the Provider should be well aware of the issues for which it is dissatisfied shortly after the issuance of the NPR. The Provider has 5 months after the end of the cost report period to file its cost report. The NPR is issued within 12 months after the cost report filing. The Provider can request a hearing within 180-days of the NPR. The Provider should have ample time to appeal the items for which it is dissatisfied during the 180-day appeal filing time period. In order to allow for an additional 60-day period, the 180-day time period for filing an appeal should be changed to a 240-day time period to accomodate the adding of issues, otherwise, the 60-day period should not be allowed. Many Providers have added issues to outstanding appeals well after the 180-day filing period. In fact, providers repeatedly add issues after the submission of final position papers, thus, requiring the filing of supplemental position papers. This process created inefficiencies for the parties to the appeal as well as the Board. Therefore, we believe it is appropriate to establish a deadline for adding issues to appeals before the commencement of any Board proceeding. Finally, how would the appeals filed prior to the new rule be implemented? Could Provider's add issues for 60-days or would they be grandfathered in and allowed to add issues prior to the hearing?

Issues 11-13

REOPENING PROCEDURES

In proposed paragraph (c)(3) it would be stated that the intermediary may reopen, on its own motion or on request a determination that it is currently pending on appeal before the Board or Administrator. The scope of the reopening could include any matter covered by the determination, including those specific matters that have been appealed to the Board or Administrator. The Intermediary would be required to notify the Board of the reopening. It is overly burdensome and impractical to require the intermediary to notify the Board each and every time a reopening occurs for a Provider cost report that is also under appeal. We recommend that the Provider notify the Board of any reopenings for cost reports also under appeal. Many times home office cost reports are updated which require reopenings of the individual Provider chain components. These individual cost reports are automatically reopened by the Intermediary even though the cost report is under appeal. It would be impractical to continually determine when a concurrent reopening and appeal are present and notify the Board.

1. REOPENING AN INTERMEDIARY OR SECRETARY DETERMINATION OR REVIEWING ENTITY DECISION.
A reviewing entity may reopen a cost report, at any time, where the determination or decision was procured by fraud or other similar fault. CMS should define fraud or other similar fault since it can be interpreted in many different ways. It would seem logical that fraud is the intential deception resulting in harm to the government resulting in a criminal conviction. Other similar fault could be interpreted to mean a judgement in a civil proceeding.

CMS-1727-P-14-Attach-1.doc

CMS-1727-P-14-Attach-1.doc

CMS-1727-P-14-Attach-1.doc

CMS-1727-P-14-Attach-1.doc

File Code CMS-1727-P

Mutual of Omaha
Comments to Proposed Rule dated June 25, 2004

Submitted electronically on August 24, 2004
To http://www. CMS.hhs.gov/regulations/ecomments

D. PROVIDER HEARING RIGHTS

4. CONTENTS OF HEARING REQUEST

The proposed rule encourages an "early focus" by the parties and the reviewing entity on the jurisdictional requirements for a hearing before the Board. The proposed rule believes it is reasonable to require the original hearing request to include a demonstration that the provider satisfies the jurisdictional requirements for the hearing request. The Board should also issue jurisdictional decisions early in the appeal process. Some jurisdictional challenges by the Intermediary are over 4 years old with no Board jurisdictional decision. Time requirements for a Board jurisdictional decision on challenges should be set. There have been many instances where a hearing is held on the merits and the jurisdictional issues concurrently. If there are no time limits imposed upon the Board, we may gravitate toward delaying these decisions which creates additional, and possibly, unnecessary work for the Provider and Intermediary.

5. ADDING ISSUES TO ORIGINAL HEARING REQUEST

The proposed rule allows Providers to add issues to the hearing request during a 60-day period, commencing with the expiration of the applicable 180-day period for submitting the original hearing request under proposed § 405.1811(a)(3) and § 405.1835(a)(3). It is our belief that the Provider should be well aware of the issues for which it is dissatisfied shortly after the issuance of the NPR. The Provider has 5 months after the end of the cost report period to file its cost report. The NPR is issued within 12 months after the cost report filing. The Provider can request a hearing within 180-days of the NPR. The Provider should have ample time to appeal the items for which it is dissatisfied during the 180-day appeal filing time period. In order to allow for an additional 60-day period, the 180-day time period for filing an appeal should be changed to a 240-day time period to accommodate the adding of issues, otherwise, the 60-day period should not be allowed. Many Providers have added issues to outstanding appeals well after the 180-day filing period. In fact, providers repeatedly add issues after the submission of final position papers, thus, requiring the filing of supplemental position papers. This process creates inefficiencies for the parties to the appeal as well as the Board. Therefore, we believe it is appropriate to establish a deadline for adding issues to appeals before the commencement of any Board procedures. Finally, how would the appeals filed prior to the new rule be implemented? Could Provider's add issues for 60-days or would they be grandfathered in and allowed to add issues prior to the hearing?

M. QUORUM REQUIRMENTS

The proposed rule clarifies that more than one hearing may be held simultaneously. The Board Chairman could designate one Board member to conduct a hearing. Under the proposal, it would not be necessary for the Board Chairman to obtain the approval of the provider or the intermediary before he or she could assign less than a quorum to conduct a hearing. We believe that it is necessary to have at least 2 Board members present at live hearings. This is necessary to ensure that differing views/opinions/ experiences/interpretations of Board members present at live hearings do not sway the outcome of Board decisions.

N. BOARD PROCEEDINGS PRIOR THE HEARING; DISCOVERY IN BOARD AND INTERMEDIARY HEARING OFFICER PROCEEDINGS

It is proposed that each position paper set forth the relevant facts and arguments concerning the Board's jurisdiction over each remaining issue in the appeal, and that any supporting exhibits must accompany the position paper. These proposed requirements is intended to facilitate the Board's ability to make preliminary findings as to whether it has jurisdiction with respect to each specific matter at issue. The Board should issue jurisdictional decisions early in the appeal process. Some jurisdictional challenges by the Intermediary are over 4 years old with no Board jurisdictional decision. Time requirements for a Board jurisdictional decision on challenges should be set. There have been many instances where a hearing is held on the merits and the jurisdictional issues concurrently. If there are no time limits imposed upon the Board, we may gravitate toward delaying these decisions which creates additional, and possibly, unnecessary work for the Provider and Intermediary. Preferably, all Board jurisdictional decisions should be rendered before the Board's acknowledgement letter goes out establishing due dates for position papers and scheduling a tentative hearing month. Moreover, all Board jurisdictional decisions should be published for public viewing.

V. REOPENING PROCEDURES

In proposed paragraph (c)(3) it would be stated that the intermediary may reopen, on its own motion or on request a determination that is currently pending on appeal before the Board or Administrator. The scope of the reopening could include any matter covered by the determination, including those specific matters that have been appealed to the Board or the Administrator. The Intermediary would be required to notify the Board of the reopening. It is overly burdensome and impractical to notify the Board each and every time a reopening occurs for a Provider cost report under appeal. We recommend that the Provider notify the Board of any reopenings for cost reports also under appeal. Many times home office cost reports are updated which require reopenings of the individual Provider chain components. These individual cost reports are automatically reopened by the intermediary even though the cost report is under appeal. It would be impractical to continually determine when a concurrent reopening and appeal are present and notify the Board.

1. REOPENING AN INTERMEDIARY OR SECRETARY DETERMINATION OR REVIEWING

ENTITY DECISION

A reviewing entity may reopen a cost report, at any time, where the determination or decision was procured by fraud or similar fault. CMS should define fraud or similar fault since it can be interpreted in many different ways. It would seem logical that fraud is the intentional deception resulting in harm to the government resulting in a criminal conviction. Other similar fault could be interpreted to mean a judgement in a civil proceeding.

Submitter : Ms. Marilyn Litka-Klein **Date & Time:** 08/24/2004 06:08:08

Organization : Michigan Health & Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see our attached comments.

Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Offices of Strategic Operations and Regulatory Affairs

The attachment to this document is not provided because:

1. The document was improperly formatted.
2. The submitter intended to attach more than one document, but not all attachments were received.
3. The document received was a protected file and can not be released to the public.
4. The document is not available electronically at this time. If you like to view any of the documents that are not posted, please contact CMS at 1-800-743-3951 to schedule an appointment.

Submitter : Ms. Marilyn Litka-Klein **Date & Time:** 08/24/2004 07:08:38

Organization : Michigan Health and Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see our attached comments.

CMS-1727-P-16-Attach-1.doc

CMS-1727-P-16-Attach-2.doc

August 20, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1727-P
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Proposed Rule for Provider Reimbursement Determinations and Appeals as published in the June 25, 2004 Federal Register (69 Fed. Reg. 35715 - 35766).

Dear CMS Administrator:

On behalf of 143 Michigan hospitals, the Michigan Health & Hospital Association appreciates the opportunity to comment on the CMS Proposed Rule published in the June 25, 2004 Federal Register relating to Provider Reimbursement Determinations and Appeals. We agree with CMS's goal to update, clarify and revise the regulations to promote a more effective and efficient appeals process. We also agree that the regulations should reflect longstanding policies of CMS and the Provider Reimbursement Review Board ("PRRB" or "Board"), such as those proposed regulations related to cost report reopenings for example. Additionally, we appreciate the proposals related to clarification of procedural issues, such as filing dates and dates of receipt.

However, we are concerned with several matters proposed by CMS because we feel they substantially alter important rights to which Providers are currently entitled. Finally, we are concerned with a perceived imbalance between parties' rights within the proposed rules limiting Provider rights and actions while maintaining those of Intermediaries. Historically, hospitals have viewed it to be imbalanced against Providers, and certainly unenforceable by the PRRB when Intermediaries are at fault without asking for CMS to help monitor its contractors.

"Provider Hearing Rights"

1. Revised Self-Disallowance Policy

CMS proposes to alter 42 C.F.R. §§ 405.1811(a)(1) and 405.1835(a)(1) to address the "self-disallowance policy" as mandated by statute and the United States Supreme Court in Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988). Under the proposed regulation, to preserve an issue for

appeal, a Provider must declare the item in its as-filed cost report as a "protested amount" under Provider Reimbursement Manual § 115.

CMS offers no explanation in the Federal Register as to how this change can be consistent with the Supreme Court's decision in Bethesda. In Bethesda the Court ruled that "the plain meaning of the statute decides the issue presented" rejecting the "strained interpretation" of the Secretary as "inconsistent with the express language of the statute." Id. at 403-404. It is not possible to alter by regulation a statute and right the Supreme Court has determined is mandated by the plain words of the statute. Notably, the Supreme Court concluded that providers can "claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediaries." The proposed rule directly contradicts the Supreme Court's statement by mandating that a provider must claim dissatisfaction by incorporating a challenge into its cost report through either declaring the item as a cost or declaring it as a protested item.

The Supreme Court in Bethesda based its decision on the language in § 1878(d) of the Social Security Act giving the Board power to "review and revise a cost report with respect to matters not contested before the fiscal intermediary." Id. at 406. In on-point language the Supreme Court ruled that "the only limitation prescribed by Congress is that the matter must have been 'covered by such cost report,' that is, a cost or expense that was incurred within the period for which the report was filed, even if such cost or expense was not expressly filed." Id. The Supreme Court has spoken on this point, and CMS by regulation cannot alter the Supreme Court's clearly stated interpretation of the statutory mandate. The statute explicitly states that Board jurisdiction exists even for costs or expenses not expressly filed and therefore not considered by the Intermediary. In requiring costs or expenses to be specifically filed under protest to preserve appeal rights the proposed regulation is in direct conflict with the plain language of the statute as interpreted by the United States Supreme Court.

CMS bases its proposed requirement to expressly file a cost or expense to preserve appeal rights on the dissatisfaction requirement in § 1878(a)(1) of the Social Security Act. CMS reasons that a provider cannot be "dissatisfied" within the meaning of the statute unless the provider expresses a desire for payment for an item that is then denied. This emphasis on specific items is not found in the statute. Rather, the dissatisfaction requirement is explicitly in the context of simply "the amount of payment" under the cost report. Under the statute, a hospital's appeal rights confer from its dissatisfaction with total "amount of payment" and not necessarily from dissatisfaction related to specific items claimed and denied, or self-disallowed.

2. Adding Issues to Original Hearing Request

CMS proposes to substantially alter the long standing right of providers to add issues to an already perfected appeal. CMS acknowledges this right has existed without substantial change for 30 years, but proposes to now greatly restrict the ability to add issues by requiring that additional issues be added within 60 days of the 180 day period to submit an appeal.

CMS cites no statutory basis for this change, arguing only that it is permitted notwithstanding § 1878(d)'s explicit statement that it has the power to review any "matters covered" by a cost report including those "not considered by the intermediary in making such a final determination." The Supreme Court's decision in Bethesda is again informative on this matter. The Supreme Court has made clear that once jurisdiction for a cost reporting year is established the only requirement is "that the matter must have been 'covered by such cost report.'" Bethesda at 406.

CMS's justification for this substantial erosion of Provider appeal rights is that the ability to add issues has "become a major obstacle to the Board's effort to reduce . . . its backlog." CMS does not explain how adding issues to an already existing appeal in anyway affects an already existing backlog. An appeal would be before the Board regardless of whether more issues are added to it. As discussed below, the MHA has found that the ability to add issues allows flexibility in negotiations which often result in administrative resolution of cases without proceeding to a full Board hearing and potential appeal beyond.

We disagree with the CMS's claim that the 60 day limit "would strike an appropriate balance" between the need to supplement a hearing request and the imperative to reduce case backlog. First, there is little balance in the proposal. The amount of time to add an issue is minimal in the context of the time involved with most cases. Second, there is no balance in regard to similar restrictions on the Intermediary. We have found that Intermediaries often wait until very late in the process to review the issues and to raise their own additional matters, such as jurisdictional challenges. A jurisdictional challenge can be far more disruptive to the appeals process, often forcing a rescheduling of the entire proceeding, than merely adding an issue to an existing appeal. In addition, this rule change could itself result in yet more such challenges and delay. An argument appearing in the Provider's Position Paper might be interpreted as a "new issue" by the Intermediary which would then challenge that issue as untimely added. The Board need not hear such disputes now, but it likely will under this proposed change. Finally, we have found that the ability to add issues often allows the Intermediary and Provider in final negotiations to resolve the appeal. Removing this ability could actually force more cases to hearing and aggravate the problems of an overcrowded Board docket.

Still, the MHA is sensitive to the Board's concerns with streamlining the process and we acknowledge the benefits to the parties of expeditious hearings and the value of reducing the Board's backlog of cases. However, given the necessary length of time that complex Medicare cases often take, a better balance would be achieved by linking the time period to add issues to deadlines directly related to the imminence of the Board hearing. In particular the MHA proposes the following alternative provision:

1. Providers would be required to add issues no later than 60 days prior to the deadline established by the PRRB to submit Final Position Papers.

2. The above requirement should be waivable by agreement of both the Provider and the Intermediary.

3. Similarly, the Intermediary should be required to raise any jurisdictional challenges not later than 60 days prior to the deadline established by the PRRB to submit Final Position Papers.

We appreciate CMS's consideration of this alternative approach. We feel this approach would be equitable to both sides, while streamlining the process substantially, and would be more reasonable by basing the deadline for adding issues on the PRRB's objective schedule for hearing the appeal itself. In addition, this approach further serves the PRRB's desire to avoid disruptive late issues being raised by imposing the same deadline for Intermediary jurisdictional challenges, thus creating balance between the rights of the parties. We are very concerned that the proposed regulation as written goes too far in limiting the right of Providers to add issues and that this significant erosion of Provider rights will combine with the proposed regulation related to self-disallowances discussed above to erode statutory appeal rights of Providers.

As an additional technical matter, some MHA hospitals have requested clarification of when the proposed 60 day time limit to add issues ends. Does it end 60 days from when the Provider submits its appeal or 60 days from the end of the 180 day period the Provider had to file its appeal regardless of when the appeal was submitted? Put another way, does the proposed 60 day limit end 240 days from the Provider's receipt of the NPR?

3. Right To Board Hearing

CMS proposes to revise 42 C.F.R. § 405.1835 to require that certain detailed information be submitted with Providers' initial requests for hearing, e.g. how and why the Provider believes Medicare payment must be determined differently for each disputed item. We are concerned that the detailed information required for the content of the initial hearing request will unduly burden smaller, rural, and less sophisticated Providers who will not have the ability to file appeals without the assistance of outside expertise. In addition, we are concerned that the codification of detailed information requirements will remove the Board's flexibility to accept appeals. Certain Providers could therefore be restricted from the appeals process altogether due merely to the complexity involved with filing the initial hearing request.

Again, we appreciate the opportunity to comment on these proposed regulations which will directly affect Michigan hospitals. While we agree the time has come to streamline the appeals process, we feel the proposed regulations as currently drafted are too restrictive of Providers' rights and ability to file appeals with the PRRB. The MHA was assisted by staff of Hall, Render, Killian, Health & Lyman, P.S. C., in the development of these comments.

Sincerely,

Marilyn Litka-Klein

Submitter : Mr. Ronald Hendrickson **Date & Time:** 08/24/2004 07:08:19

Organization : International Chiropractors Association

Category : Chiropractor

Issue Areas/Comments

GENERAL

GENERAL

DATE: August 24, 2004

TO: US Department of Health and Human Services,
Centers for Medicare & Medicaid Services

FROM: International Chiropractors Association

SUBJECT: Comments on CMS-1727-P

The International Chiropractors Association (ICA) welcomes the opportunity to comment on proposed rule changes dealing with provider appeal processes and rights as published in the July 25, 2004 Federal Register. ICA represents the interests and concerns of both patients and providers, and is concerned that the general approach represented by these rule changes will only serve to erode the fairness and effectiveness of an already complex, expensive and time-consuming appeals process, but one that does ultimately work.

Under the ?Provider Hearing Rights?, ICA is concerned with new provisions that obligate the provider to document and provide argument that their claims appeal(s) are strictly and demonstrably within the jurisdiction of the appeals panel, a function that rightfully should reside with the agency. Likewise, requirements for documentation regarding self-disallowance issues seems to unfairly shift the burden entirely onto the provider, without offering detailed and specific criteria for what is and what is not acceptable documentation and standards of argument.

Under ?Provider Requests for Extension?, the Agency cites extensive backlogs as a basis for altering the circumstances under which providers may request a good cause extension request. CMS does not provide for circumstances in which the Agency and/or appeals personnel are a contributing factor in delaying a timely appeal. The long response times, the frequent failure of carriers and other parties to the review process, to respond to written inquiries, etc., is continually problematic, and should be addressed.

Under ?Expediting Judicial Review?, the ICA is concerned that the revision of section L. ?Parties to a Board Hearing?, that provide CMS with a participation pathway beyond that of ?party to the haring? provides a means for CMS policy officials to influence the process without the prospect of inquiry or cross-examination by the appellant. We are concerned that this provision establishes a means to skew the process without the basis to appropriately pursue questions regarding statements made and questions raised through that process, directly to those making any amicus curiae submissions.

Regarding the section captioned, ?Three Additional Proposals Under Consideration?, the third issue, dealing with the reversal of an intermediary denial and the focus of seeking additional means for a further denial raises serious concerns. From the provider perspective, it appears that this proposed action, along with the greater body of proposed amendments, are following a pattern of added demands and requirements that are designed not to streamline the process, but to have a chilling effect on the willingness and capacity of providers to appeal legitimate concerns. This is a very inappropriate manner in which to address the backlog issues continually referenced throughout the July 25th proposed rule.

ICA appreciates this opportunity to comment on the proposed rules.

Respectfully Submitted,

Ronald M. Hendrickson
Executive Director

RMH/nip

Submitter : **Date & Time:** 08/24/2004 07:08:06

Organization : AdminaStar Federal, Inc.

Category : Health Care Industry

Issue Areas/Comments

Issues 1-10

PROVIDER HEARING RIGHTS

The section clearly covers 'costs claimed' and 'self-disallowances'. Change of elections for reporting costs claimed does not fit into either category. Or is this not subject to appeal under 405.1835 (a)(1) since there is no dissatisfaction caused by the Intermediary, as it is not a specific determination covered under the NPR.

The terminology in section 3 'ending date of the appeal period' should be changed to the 'ending date for purposes of determining timeliness'. The appeal period ends at 180 days, which may be before the receipt of the request for hearing. The proposed wording in the regulation is clear.

We support the recommendation to limit the adding of issues to a 60-day period. While we believe the initial 180 day period to file an appeal should be sufficient, any limitation is appropriate.

Submitter : **Date & Time:** 08/24/2004 08:08:21

Organization : AdminaStar Federal, Inc.

Category : Health Care Industry

Issue Areas/Comments

Issues 1-10

BOARD PROCEEDINGS PRIOR TO HEARING

The last sentence under subsection 4 "Contents of Hearing Request" indicates "the hearing request would no longer need to include documents necessary to support the merits of the provider's position..." This sentence appears to be in conflict with the first paragraph of this subsection and the proposed wording in 405.1835(b)(2). The provider must supply documentation before any subsequent meetings can be productive. Therefore, we believe the supporting documentation must be included with the hearing request.

EXPEDITING JUDICIAL REVIEW

The EJR section covers the effects of a filed lawsuit during the EJR process. What happens if a Provider files an appeal and/or reopening and a lawsuit at the same time and has not asked for EJR. This recently happened with the Monmouth cases. Some cases had all three avenues filed and working simultaneously. Clear guidance is needed regarding the impact of a lawsuit on appeals and/or reopenings.

'Parties to a Board Hearing'

The proposed regulations states the 'Board' may call any employee of HHS/CMS as a witness. Can the Intermediary? For example, routine cost limit cases are currently handled directly by CMS. A CMS employee is used as a witness.

GROUP APPEALS

The use of the phrases 'each specific cost at issue' and 'each disputed cost at issue' here and in the proposed 405.1837(c)(2) are misleading since group appeals are limited to one issue.

Issues 11-13

COLLECTION OF INFORMATION REQUIREMENTS

"Additional Proposals"

We agree that if determinations are reversed, that CMS should be allowed to perform the necessary audit steps needed to assure that the costs being allowed are proper. Many current appeals address issues that have not been previously audited.

REOPENING PROCEDURES

Once an issue is reopened, is there another three-year reopening period for that specific issue? The provider has 180 days to appeal the specific adjustment, so we believe the intermediary should have the same timeframe to correct clerical errors/obvious mistakes. However, another 3-year period seems excessive.

CMS-1727-P-20

Submitter : Mr. Joseph Willey **Date & Time:** 08/24/2004 08:08:45

Organization : Katten Muchin Zavis Rosenman

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Attached are comments to provider hearing rights, group appeals and "additional proposals under consideration".

CMS-1727-P-20-Attach-1.doc

575 Madison Avenue
New York, NY 10022-2585.
212.940.8800 office 212.940.8776 fax..
August 24, 2004
JOSEPH V. WILLEY
joseph.willey@kmzr.com
212.940.7087 212.940.6738 fax
Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1727-P
P.O. Box 8017
Baltimore, MD 21244-8017
Re: Proposed Rule for Medicare Program Provider Reimbursement Determinations and Appeals, 69 Fed. Reg. 35716 (June 25, 2004), CMS 1727-P: Provider Hearing Rights, Group Appeals and "Additional Proposals Under Consideration"
Dear Dr. McClellan:

We represent the New York City Health and Hospitals Corporation ("HHC"), which is affected by the purported policy that prohibits adding new issues to a group appeal pending before the Provider Reimbursement Review Board (the "Board"). CMS has proposed to codify such a policy in 42 C.F.R. § 405.1837(f)(1). 69 Fed. Reg. at 35752.

Providers under common ownership or control, such as those operated by HHC, are prejudiced by CMS's proposal in that they are required to bring any appeal involving a common issue of fact or law as a group appeal (see § 405.1837(b)(1)) but are simultaneously precluded from adding new issues to a validly pending group appeal. The preamble states (p. 35724) that under proposed § 405.1835(c)(3), an individual provider who timely requests a hearing before the Board will have an opportunity to add new issues to its appeal "no later than 60 days after the expiration of the applicable 180-day period prescribed" for requesting a Board hearing, although providers in group appeals have no such right under CMS's "longstanding interpretations" of the regulations. We submit that it is unfair to allow providers in individual appeals to add issues but not to allow providers in group appeals to do so, particularly when providers under common ownership or control have no choice but to commence their appeals as group appeals. Such a policy treats similarly situated providers differently.

We respectfully request that CMS allow providers participating in a group appeal to add an appeal issue after the 180-day deadline for commencing appeals. Such a new issue could be added to the existing group appeal, if the new issue is applicable to all participants. (CMS could to that extent also modify its proposal that would otherwise limit group appeals to a single issue [p. 35727-29, re § 405.1837(f)(2)].) Or, depending on the number of participants seeking to add the new issue, a new group or individual provider appeal could be established.

Thus, for example, if all the members of a group appeal wished to add a new issue, CMS could allow a second issue to be added to the existing appeal or it could authorize the Board to establish a separate group appeal addressing the new issue. If fewer than all of the members of the group wished to

add the new issue, the Board could establish a second group appeal on that issue for those providers. If only one member of the group wished to add the new issue, the Board could establish an individual provider appeal addressing the new issue.

We also urge that CMS maintain the current regulatory provision that allows an appeal issue to be added up to the time of Board hearing, which we believe is authorized by the Medicare Act. CMS states in the preamble (p. 35724) that the current provision allowing issues to be added up to the time of hearing was adopted at a time when hearings were conducted expeditiously, thereby leaving a relatively short time for the addition of new issues. But providers frequently do not discover a new issue until they are preparing their position papers, which may not be required by the Board until several years after an appeal is filed. Thus, we submit that CMS should allow new issues to be added to an appeal at least up to the time that final position papers are due.

We are also particularly struck by one of the "Additional Proposals Under Consideration" as described at p. 35742:

". . . [W]here CMS or the intermediary denies reimbursement for an item on one basis and that determination is reversed, CMS or the intermediary should then have the opportunity to determine whether reimbursement should be allowed or whether reimbursement should be denied for any other reason. For example, if CMS were to deny a provider's request for an exception to its ESRD payment rate on the basis that the request was not submitted timely, and if this determination were reversed by a court order that has become final and non-appealable, CMS would then determine whether the provider's exception request is allowable -- the exception request would not be granted simply because the court found that it was timely submitted. This latter proposal is consistent with our longstanding view and we believe it is appropriate in light of the need to conserve administrative resources. . . ." (Emphasis added.)

First, we submit that the recited "example" seems to be a misleading one, given the possible breadth of this Proposal. We agree that if CMS were to deny an ESRD exception request as untimely, that exception request would not and should not be granted "simply because" a court ultimately rules that its submission had indeed been timely. The substantive merits of the request would remain to be determined in such a case.

But the Proposal seems to contemplate -- far beyond the above example -- that where CMS or the intermediary purports to issue a final determination concerning the merits of a reimbursement item, and that determination is reversed by a court, there can nonetheless be a never-ending procession of remand, re-determination, appeal, judicial review, and further re-determination.

Such an approach is inappropriate in light of the need to conserve the resources of administrators, providers, and courts. Even assuming the decision-maker's "good faith" (surely a question of fact), it is a waste of resources for everyone involved to litigate reimbursement items repeatedly, piecemeal, rather than addressing any substantive issues in a single proceeding, once and for all.

Such a piecemeal approach is also improper as a matter of law.

Issues of finality must be paramount particularly where the issue concerns a Medicare Notice of Program Reimbursement ("NPR"). The Medicare Act states (§§ 1878(a), (f) [42 USC 1395oo]) that an NPR is "a final determination of the [fiscal intermediary] as to the amount of total program reimbursement due the provider . . . for the period covered . . . ." (The regulations confirm [42 CFR §§ 405.1801(a), .1807] that the NPR is "final and binding" except to the extent that it may be reopened or revised pursuant to specifically-authorized procedures.) The statute does not state, and cannot be read

to mean, that an NPR may be revisited whenever an intermediary or CMS loses a court case. No such regulatory proposal can be lawful. Yet that seems to be the Proposal at hand.

Moreover, the concept and policies underlying res judicata should govern. It is improper for an administrator to expect a court to address the merits of a disallowance decision more than once, to wit, whenever the administrator believes that its decision (having been ruled unlawful on the first reason proffered by the administrator) can be supported by some "other reason," as the Proposal suggests.

We submit that it is in any event a mistake to propose this "rule" in the absence of "specific regulatory text language" (p. 35742, 1st full paragraph). Agency rulemakings should and must propose rules, not principles. Without text, there is no rule. And it is a fortiori impossible to comment fully on a proposed "rule" before its text is proposed.

Without prejudice, HHC also objects and reserves the opportunity to object to each and every provision of the Proposed Rulemaking to the extent that any provision may be adopted as a rule and then sought to be applied to HHC's detriment in any then-pending administrative or litigated matter.

Thank you for your consideration.

Sincerely,

Joseph V. Willey

1
41315182.02

41315182.02

3
41315182.02

41315182.02

Submitter : Juby George-Vaze **Date & Time:** 08/24/2004 09:08:41

Organization : Self

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

File code: CMS-1727-P 2-D Provider hearing rights and possibly under other section. As a Nurse who worked in Managed Care and actually dealt with the denials and appeals process, I want to add that when you make these changes please consider the practical applications that affects the patient and the provider who are trying to accomplish the same goal which is to improve the members health status. There is a definite increase in denials being issued, and if not pursued through 2nd and external level options, the provider is adversely impacted. The regulations are heavily weighted in favor of the payors. In many cases there is only one level of internal appeal. External appeals can only be submitted for retrospective denials. So the concurrent denials only have one level of appeal with the payor. Additionaly external appeals require patient signature on a specific form which can only be completed after the denial has been issued. In many cases the patient has been already discharged from the inpatient setting. Obtaining the patient consent on a specific form is very difficult and in most cases eliminates external appeal. If the patient is held harmless and signed a realease of medical information on admission, then why is this form required in order for the facility to do an external appeal?

Application of criterias used to make determinations are often incorrectly applied. For example, Milliman criteria is based on data collected from thousands of claims. The criteria for an individual diagnosis is for an individual within an age range for a single diagnosis only. The average age range for this criteria is between 32 and 54 years of age. Most medicare beneficiaries are not in that age group and usually have multiple diagnoses. Therefore applying these criterias as absolutes with no consideration of age or the number of comorbidities is highly inappropriate. Additionally, the Medical Directors applying the criteria should be certified in their use and proper applications. Medicare surveyors should not only look at the number of denials, the proper time frame applications, but also the appropriate application of the criteria.

Since hospitals and providers must meet the regulatory requirement in submission of appeals, the payor should have a set time frame to make a determination and notify the affected parties. A suggestion would be 60days. If the time frame is not met by the payor then there should be financial consequences. An example would be the New York state policy of automatic reversal of the denial if the payor didn't meet the 60day response timeframe.

As a practitioner who have observed actual implementation of the current CMS policies and Managed Care Organization (MCO) policies, I highly encourage you to make this process more equitable for the providers who take the risk of giving care with out knowing if they are going to receive reinbursement.

Submitter : Mr. Jim Wentz **Date & Time:** 08/23/2004 12:08:00

Organization : St Paul and Zale Lipshy University Hospitals

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

CMS-1727-P Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary.s refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI.s failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states .A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition.. It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.
3. We disagree that a party.s discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate. 4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas
-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.

-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

Submitter : Mrs. Judith Ghobrial **Date & Time:** 08/24/2004 12:08:00

Organization : Harris County Psychiatric Center

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

FILE CODE CMS-1727-P

Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary.s refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI.s failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states .A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition.. It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.
3. We disagree that a party.s discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas

-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

Submitter : Ms. Carla Davila **Date & Time:** 08/24/2004 12:08:00

Organization : BAPTIST HEALTH SERVICES

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comment

CMS-1727-P-24-Attach-1.doc

FILE CODE CMS-1727-P

Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary's refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI's failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states "A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition." It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.

3. We disagree that a party's discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas
-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

Submitter : Mr. Rudy Garcia **Date & Time:** 08/24/2004 12:08:00

Organization : The Institute for Rehabilitation and Research

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

FILE CODE CMS-1727-P

Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary.s refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI.s failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states .A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition.. It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.
3. We disagree that a party.s discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas

-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

Submitter : Mr. John Wilson **Date & Time:** 08/24/2004 12:08:00

Organization : Texas Health Resources

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

FILE CODE CMS-1727-P

Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary.s refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI.s failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states .A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition.. It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.
3. We disagree that a party.s discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas

-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

Submitter : Ms. Patricia Andersen **Date & Time:** 08/24/2004 12:08:00

Organization : Oklahoma Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See Attached Comments

CMS-1727-P-27-Attach-1.doc

FILE CODE CMS-1727-P

Calculating Time Periods

II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR

-Restriction is not logical and actually creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because no provider could know what the FI would later decide to audit.

Provider Hearing Rights

II.(D)(1) ways to obtain a Board hearing

-Need to add (iii) the Intermediary's refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists. This would be unfair to providers.

II.(D)(1) filing a cost report under protest

-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FIs because it has to be claimed and the impact manually calculated. The FIs then must manually review each protested item and decide to remove or allow. The FI's failure to do that would automatically reimburse Providers.

II.(D)(3) the expiration of the 12-month period for issuance of the NPR

-Restriction is not logical and actually creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because no provider could know what the FI would later decide to audit.

II.(D)(4) hearing request to include a description of each self-disallowed item

-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FIs because it has to be claimed and the impact manually calculated. The FIs then must manually review each protested item and decide to remove or allow. The FI's failure to do that would automatically reimburse Providers.

II.(D)(5) 60-day add issues period

-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M) assigning less than a quorum to conduct a hearing

-The Board should be required to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing

II.(N) proceedings prior to hearing

1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.

2. We disagree with the method of discovery, the limiting of interrogatories and depositions, specifically the section which states, "A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition." It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.

3. We disagree that a party's discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.

4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas

We disagree that a party's discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.

II.(P) Administrator excluding or including evidence not in the record.

-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

CMS-1727-P-28

Submitter : Ms. Lacey Walsh **Date & Time:** 08/24/2004 12:08:00

Organization : Memorial Health System of East Texas

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

Please see attached document

CMS-1727-P-28-Attach-1.doc

FILE CODE CMS-1727-P Attach # 28

Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary's refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI's failure to do that would automatically reimburse Providers
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states "A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition." It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.

3. We disagree that a party's discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas
-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.

CMS-1727-P-29

Submitter : Mr. John C Render, Esq. **Date & Time:** 08/24/2004 12:08:00

Organization : Indiana Hospital&Health Association

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Attached are comments submitted on behalf of The Indiana Hospital&Health Association ("IHHA") by IHHA General Counsel Hall, Render, Killian, Heath & Lyman, P.S.C.

CMS-1727-P-29-Attach-1.doc

HALL,
RENDER, KILLIAN,
HEATH & LYMAN

Attorneys at Law

Professional Service Corporation

Suite 2000, Box 82064
One American Square, Indianapolis, IN 46282
(317) 633-4884 Fax: (317) 633-4878

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1727-P**
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Commentary on behalf of The Indiana Hospital&Health Association on Proposed Rule for Provider Reimbursement Determinations and Appeals as published in the June 25, 2004 Federal Register (69 Fed. Reg. 35715 - 35766)

Dear CMS Administrator:

On behalf of The Indiana Hospital&Health Association ("IHHA"), we appreciate the opportunity to comment on the CMS Proposed Rule published in the June 25, 2004 Federal Register relating to Provider Reimbursement Determinations and Appeals. We agree with CMS's goal to update, clarify, and revise the regulations to promote a more effective and efficient appeals process. We also agree that the regulations should reflect longstanding policies of CMS and the Provider Reimbursement Review Board ("PRRB" or "Board"), such as those proposed regulations related to cost report reopenings. Additionally, we applaud the proposals related to clarification of procedural issues, such as filing dates and dates of receipt.

However, we are concerned with several matters proposed by CMS because we feel they substantially alter or erode important substantive rights to which Providers are currently entitled. In addition, we seek clarification of certain aspects of proposed rules. Finally, we are very concerned with the balance between parties' rights within the proposed regulations as severely limiting Provider rights and actions while maintaining those of Intermediaries. Historically, many have viewed it to be imbalanced against Providers, perhaps unfair, and certainly unenforceable by the PRRB when Intermediaries are at fault without asking for CMS to help monitor its contractors. Therefore, the following comments related to the caption "Provider Hearing Rights" are submitted for your consideration.

"Provider Hearing Rights"

1. Revised Self-Disallowance Policy

CMS proposes to alter 42 C.F.R. §§ 405.1811(a)(1) and 405.1835(a)(1) to address the "self-disallowance policy" as mandated by statute and the United States Supreme Court in *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988). Under the proposed regulation, to preserve an issue for appeal, a Provider must declare the item in its as-filed cost report as a "protested amount" under Provider Reimbursement Manual § 115.

CMS offers no explanation in the Federal Register as to how this change can be consistent with the Supreme Court's decision in *Bethesda*. In *Bethesda* the Court ruled that "the plain meaning of the statute decides the issue presented" rejecting the "strained interpretation" of the Secretary as "inconsistent with the express language of the statute." *Id*. at 403-404. It is not possible to alter by regulation a statute and right the Supreme Court has determined is mandated by the plain words of the statute. Notably, the Supreme Court concluded that providers can "claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediaries." The proposed rule directly contradicts the Supreme Court's statement by mandating that a Provider must claim dissatisfaction by incorporating a challenge into its cost report through either declaring the item as a cost or declaring it as a protested item.

The Supreme Court in *Bethesda* based its decision on the language in § 1878(d) of the Social Security Act giving the Board power to "review and revise a cost report with respect to matters not contested before the fiscal intermediary." *Id*. at 406. In language directly applicable to this issue the Supreme Court ruled that "the only limitation prescribed by Congress is that the matter must have been 'covered by such cost report,' that is, a cost or expense that was incurred within the period for which the report was filed, *even if such cost or expense was not expressly filed*." *Id*. The Supreme Court has spoken on this point, and CMS by regulation cannot alter the Supreme Court's clearly stated interpretation of the statutory mandate. The statute explicitly states that Board jurisdiction exists even for costs or expenses not expressly filed and therefore not considered by the Intermediary. In requiring costs or expenses to be specifically filed under protest to preserve appeal rights the proposed regulation is in direct conflict with the plain language of the statute as interpreted by the United States Supreme Court.

CMS bases its proposed requirement to expressly file a cost or expense to preserve appeal rights on the dissatisfaction requirement in § 1878(a)(1) of the Social Security Act. CMS reasons that a Provider cannot be "dissatisfied" within the meaning of the statute unless the Provider expresses a desire for payment for an item that is then denied. This emphasis on specific items is not found in the statute. Rather, the dissatisfaction requirement is explicitly in the context of simply "the amount of payment" under the cost report. Under the statute, a Provider's appeal rights confer from its dissatisfaction with total "amount of payment" and not necessarily from dissatisfaction related to specific items claimed and denied, or self-disallowed.

2. Adding Issues to Original Hearing Request

CMS proposes to substantially alter the long standing right of Providers to add issues to an already perfected appeal. CMS acknowledges this right has existed without substantial change for 30 years, but proposes now to greatly restrict the ability to add issues by restricting the addition of issues to 60 days after the 180 day period to perfect an appeal.

CMS cites no statutory basis for this change, arguing only that it is permitted notwithstanding the explicit statement of § 1878(d) that it has the power to review any "matters covered" by a cost report including those "not considered by the intermediary in making such a final determination." The Supreme Court's decision in *Bethesda* is again informative on this matter. The Supreme Court has made clear that once jurisdiction for a cost reporting year is established the only requirement is "that the matter must have been 'covered by such cost report.'" *Bethesda* at 406.

CMS's justification for this substantial erosion of Provider appeal rights is that the ability to add issues has "become a major obstacle to the Board's effort to reduce . . . its backlog." CMS does not explain how adding issues to an already existing appeal in any way affects an already existing backlog. An appeal would be before the Board regardless of whether more issues are added to it. As discussed below, the IHHA member Hospitals have found that the ability to add issues allows flexibility in negotiations which often result in administrative resolution of cases without proceeding to a full Board hearing and potential appeal beyond.

We disagree with CMS's claim that the 60 day limit "would strike an appropriate balance" between the need to supplement a hearing request and the imperative to reduce case backlog. First, there is little balance in the proposal. The amount of time to add an issue is minimal in the context of the time involved with most cases. Second, there is no balance in regard to similar restrictions on the Intermediary. We have found that Intermediaries often wait until very late in the process to review the issues under appeal and to raise their own additional concerns, such as jurisdictional challenges. A jurisdictional challenge can force rescheduling of an entire proceeding thereby being far more disruptive to the appeals process than merely adding an issue to an existing appeal. In addition, this rule change could itself result in yet more such jurisdictional challenges and delay. An argument appearing in the Provider's Position Paper might be interpreted as a "new issue" by the Intermediary which could then challenge that issue as untimely added. The Board need not deal with such disputes now, but it likely will under this proposed change. Finally, we have found that the ability to add issues often allows the Intermediary and Provider in final negotiations to resolve the appeal. Removing this ability to consider additional issues could actually force more cases to hearing and aggravate the problems of an overcrowded Board docket.

Still, the IHHA is sensitive to the Board's concerns with streamlining the process and we acknowledge the benefits to the parties of expeditious hearings and the value of reducing the

Board's backlog of cases. Given the necessary length of time that complex Medicare cases often take, a better balance would be achieved by linking the time period to add issues to deadlines directly related to the imminence of the Board hearing. In particular the IHHA proposes the following alternative provision:

1. Providers would be required to add issues no later than 60 days prior to the deadline established by the PRRB to submit Final Position Papers.

2. The above requirement would be waivable by agreement of both the Provider and the Intermediary.

3. Similarly, the Intermediary would be required to raise any jurisdictional challenges not later than 60 days prior to the deadline established by the PRRB to submit Final Position Papers.

We appreciate CMS's consideration of this alternative approach. We feel this approach would be fair, while still streamlining the process substantially, and would be more reasonable by basing the deadline for adding issues on the PRRB's objective schedule for hearing the appeal itself. In addition, this approach further serves the PRRB's desire to avoid disruptive late issues being raised by imposing the same deadline for Intermediary jurisdictional challenges, thus creating balance between the rights of the parties. We are very concerned that the proposed regulation as written goes too far in limiting the right of Providers to add issues and that this significant erosion of Provider rights will combine with the proposed regulation related to self-disallowances discussed above to substantially erode statutory appeal rights of Providers.

As an additional technical matter, IHHA member Hospitals request clarification of when the proposed 60 day time limit to add issues ends. Does it end 60 days from when the Provider submits its appeal or 60 days from the end of the 180 day period the Provider had to file its appeal regardless of when the appeal was submitted? Put another way, does the proposed 60 day limit end 240 days from the Provider's receipt of the NPR? This clarification would also be resolved by the alternative provision proposed above.

3. Right To Board Hearing

CMS proposes to revise 42 C.F.R. § 405.1835 to require that certain detailed information be submitted with Providers' initial requests for hearing, e.g. how and why the Provider believes Medicare payment must be determined differently for each disputed item. We are concerned that an overly strict reading of the detailed information requirement for the content of the initial hearing request will unduly burden smaller, rural, and less sophisticated Providers who may not have the resources to file appeals without resort to outside expertise. In addition, we are concerned that the codification of detailed information requirements will remove the Board's flexibility to identify appropriate appeal issues. Certain Providers could therefore be

disadvantaged by the appeals process due merely to the complexity involved with filing the initial hearing request.

Again, we appreciate the opportunity to comment on the Proposed Rule which will directly affect IHHA member Hospitals. While we agree with the objective to streamline the appeals process, we feel the proposed provisions as currently drafted are too restrictive of Providers' rights and ability to file legitimate appeals with the PRRB.

Sincerely,

HALL, RENDER, KILLIAN, HEATH & LYMAN, P.S.C.

John C. Render

L. Richard Gohman

cc: David H. Wiesman, Vice President
Indiana Hospital&Health Association

108942_1.DOC

CMS-1727-P-30

Submitter : Mr. Irwin Cohen **Date & Time:** 08/24/2004 12:08:00

Organization : Fulbright and Jaworski L.L.P.

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Comments on Proposed Rule on Provider Determinations and Appeals - CMS-1727-P

CMS-1727-P-30-Attach-1.doc

Fulbright & Jaworski l.l.p.
A Registered Limited Liability Partnership
801 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2623
www.fulbright.com

MEMORANDUM

TO: Centers for Medical and Medicaid Services
[http://www.cms.hhs.gov/regulations/ecomments]

FROM: Irwin Cohen

DATE: August 24, 2004

RE: Comments on Proposed Rule on Provider Determinations and Appeals – CMS - 1727-P

On behalf of my many health care provider clients, and as a former Attorney Advisor to the Administrator, I am deeply concerned with certain aspects of the proposed rule in the June 25, 2004 Federal Register, CMS-1727-P. Accordingly, I submit the following comments:

GENERAL COMMENTS

I do applaud the effort to update, clarify and revise the provider reimbursement determinations and appeals regulations to attempt to make the appeal system more effective, efficient and to shorten the length of the appeal. However, the one aspect of the system that has proven to give most comfort to the provider community is the quality and the independence of the Provider Reimbursement Review Board (the "Board") itself, and that role will be diminished by the proposal. Congress, in its wisdom, established a board of independent experts in provider reimbursement issues, and empowered the Board to resolve disputes between providers and Medicare fiscal intermediaries, in hopes of eliminating the need to have disputes resolved by the Federal courts. While expecting the decisions of the Board to generally be accepted as fair by both the providers and the Medicare Program, Congress did allow for dissatisfied providers to appeal to court, expecting few to take such appeals in light of the Board's fair and independent decisions. Congress also permitted the Medicare Administrator to review and overturn Board decisions, but expected that authority to be used rarely, and only where the Board's decision was totally inconsistent with reasonable interpretation of law and regulations, NOT where the Administrator would have simply preferred a contrary decision. The Administrator's recent record in this aspect has been abysmal, with a near one hundred percent reversal of all Board decisions favorable to the providers, and almost never reversing the Board's decisions unfavorable to providers.

The results are that the Board process has become mostly useless, merely a costly and time-consuming step before being able to take an issue to court.

These regulations give the Administrator an opportunity to strengthen the Board's role and to make meaningful progress toward resolving reimbursement disputes, utilizing the rich resource it has in the Board itself. To that end, the proposed regulations have not only failed,

they have further emasculated the Board's jurisdiction and independence, which I find to be blatantly offensive. I note that Congress, in its passage of Section 931 of the MMA of 2003, raised great concerns that by moving the function of the administrative law judges who hear Medicare coverage cases from the Social Security Administration to the Department of Health and Human Services, CMS would be exercising too much control over, and diminishing the independence of the ALJs. Yet, in this proposed regulation, CMS has done exactly what Congress feared would happen in the ALJ transfer. I am hopeful that CMS will reconsider its proposal in light of the views Congress has continuously shown regarding Medicare appeals.

PROVIDER HEARING RIGHTS

1. Proposed Section § 405.1803(d) permits fiscal intermediaries to audit self-disallowed costs allowed by the appeals process, after final adjudication, and to disallow all or part of the allowed costs based on a post-decision audit. This proposal offends the judicial principal of final adjudication and gives the Medicare Program "two bites of the apple." This proposal extends the appeal adjudication time rather than shorten it. The Board has jurisdiction to hear issues of both the allowability of a cost item and the allowable amount. There is plenty of time between when a provider appeals a self-disallowed cost and when a Board hearing is held for an intermediary to audit or otherwise evaluate the amount of claim, and to raise any question regarding the allowable amount should the claim be allowed by the Board.

   If the intermediary fails to question the amount claimed before the Board, and the provider prevails in the allowability of the cost, the claimed amount should be recognized as the final allowable cost.

2. Proposed Section 405.1811(c) and 405.1835(c), limit adding issues to the original hearing request to those added within a 60-day period following the original appeal period. CMS blames the huge delays in the Board appeals coming to hearing on the ability of providers to add issues. Nothing could be further from the truth. It is because of the long delays that providers find that cost reporting years that they would have asked to be reopened to consider new issues are amazingly still open and pending before the Board. Even though open, providers would not be inclined to add issues to current appeals, if the Program's reopening provisions were more equitable, and they could be assured of having the ability to open new issues that arise within the statutory three year reopening period, as Congress intended.

   If the Administrator wants a 60-day period to add issues, it should limit the fiscal intermediary's rights to re-open and audit and adjust any further after 60 days of issuing a Notice of Program Reimbursement. If the Administrator is unwilling to limit the intermediary's right to reopen and add issues, it should not limit the provider's right.

   Finally, the Administrator should rely on the Board's discretion to permit or not permit the providers to add issues. As noted above, Congress expected the Board to have broad powers, and this is certainly one that should be left within their discretion.

"PROVIDER REQUEST FOR EXTENSION"

To permit the Administrator to review the Board's decision to grant or deny an extension, is a clear example of the Administrator's intention to gain total oversight over every aspect of the Board's decision, just the opposite of Congress's intent in creating the Board.

"CMS REVIEW IN OFFICIAL PROCEDURE"

In proposed regulation § 405.1834(d)(2), CMS may open an intermediary hearing officer's decision within 60 days of that decision being received by the Office of Hearings. This provision is totally inconsistent with all other similar provisions which give CMS the rights to open and revive a decision within 60 days of the date the provider receives the decision. It should be no different here.

If there is a problem in intermediaries sending decisions to the Office of Hearing at the same time they send them to providers, CMS should strengthen its oversight of the intermediaries, and not penalize the providers. Providers are entitled to finality, and poor internal procedures should not be justification for decreasing that right.

"PARTIES TO A HEARING"

Clearly the most offensive and blatant effort to control the Board by CMS, is to permit CMS attorneys to defend the intermediaries position before the Board. However it is phrased, it is making CMS a "Party" to the hearing. If this is the case, the rule should be that in such cases, the Administrator has no right to review and overturn the Board's decision. Also prevailing providers should be entitled to legal fees under the Equal Access to Justice provisions.

"SUBPOENAS"

We strongly object to the ability of CMS to review and overrule a Board decision to subpoena a witness or documents. This is clearly an affront to the Board's independence. We are concerned that the Administrator might abuse this power to avoid having CMS policy experts testify before the Board. This micro-managing of the Board's administrative powers is a clear example of the true intent of the proposed regulation.

"BOARD ACTIONS IN RESPONSE TO FAILURE TO GOVERN BOARD RULES"

At last we see a provision that addresses the failure of the fiscal intermediary to meet filing or procedural deadlines. Although, not equal to the penalty for the same failure by providers, i.e. dismissal of the appeal, it nonetheless permits the Board to make a decision on the written record to that point. Our concern is that all such cases will be remanded back to the Board by the Administrator to consider the intermediary's unfiled arguments. This provision is only effective, if the Administrator cannot remand or consider the arguments not in the record when the Board decides to close the record.

"BOARD HEARING DECISION"

CMS suggests in the Preamble to the proposed regulation (at 35736) that the Board has to explain "how" it gave great weight to CMS instructions (other than regulations or rulings) when it did not affirm the intermediary's adjustment. In other words, the Board would have to start with the presumption that the intermediary is correct, and justify why it did not affirm. We believe this is inconsistent with the requirements of the Administrative Procedures Act, and offends the authority and independence of the Board. The Board should merely be required to acknowledge that it considered and gave weight to the instructions, without justifying why they did not follow them. The proposal suggests that the Administrator will have grounds to reverse

the Board's decision if the Board did not follow the instructions, raising this to the same level as statues or regulations.

"ADMINISTRATION REVIEW"

1. In proposed section 405.1875(a)(1), the agency proposes that the date of the Administrator's decision is the date it is signed, not mailed or transmitted. We believe that a signed, but untransmitted decision is not official, and can be withdrawn, changed, or otherwise modified before transmission. Further the date of mailing or transmission is not subject to tampering, and can be easily confirmed. Any internal problems with getting timely administration decisions or transmission following signing should be the responsibility of the agency, and their shortcomings should not prejudice the providers. Use of the date signed rather than transmitted is inconsistent with compliance for every other deadline associated with these rules.

2. We believe that the Administrator has headed in the wrong direction with regard to the criteria for Administrator's review. The criteria should be "limited" to (not merely examples) the following:

   (1) The Board made an erroneous interpretation of law, regulation or CMS ruling.

   (2) The Board erred in refusing to admit certain evidence.

   (3) The Board has incorrectly found, assumes, or denied jurisdiction of a specific matter or issue nor provided for by statutes or regulation.

   (4) The Board's decision is not supported by substantial evidence.

   All other criteria are offensive to the powers of the Board, the Administrative Procedures Act, and the intent of Congress.

"REOPENING PROCEDURES"

As noted earlier, the reason that issues are added to Board cases is that the reopening provisions have not been fairly applied in the past. Current rules prohibit appeals of denials to reopen, and CMS has instructed intermediaries not to reopen cost reports even in cases where there is clearly good cause and where the reopening period has not expired. On the other hand, the program gives the intermediaries the unfettered right to reopen within the same period.

The proposed regulations takes away what little discretion the intermediaries had in granting reopenings, prohibiting by regulation the ability of intermediaries to reopen based on a change in legal interpretation or policies, a legitimate good cause basis for reopening. Permitting such reopenings would result in the proper and correct payment being made to providers, which is, of course, the statutory goal of the provider payment system. These limitations on reopenings are merely blatant attempts by the Administration to evade making fair payments to providers.

CONCLUSIONS

I support the effort to revise the regulations that govern the provider appeals process, viewing this as an opportunity to streamline the appeals process by giving the Board a stronger role than it has had in the past. This proposal misses that opportunity. Unfortunately, instead, the general tenor of the proposed regulations has been to narrow the authority of the Board, and to broaden the Administrator's review and control over the appeals. If finalized a proposed, the Board hearing will be a useless waste of time and costs. Providers may as well appeal directly to the Administrator, or better yet, right to federal court. If these regulations are finalized as proposed, I would foresee a major effort on the part of the provider community to seek

legislative relief to totally eliminate the Administrator's review and oversight and to restore the Provider Reimbursement Review Board to the role Congress clearly intended it to have.

Respectfully submitted,

Irwin Cohen

Submitter : Mr. Rick Pollack **Date & Time:** 08/24/2004 12:08:00

Organization : American Hospital Association

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

AHA comments regarding MMA, Provider Reimbursement Determination and Appeals are attached.

CMS-1727-P-31-Attach-1.doc

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

August 24, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Sent via email to: http://www.cms.hhs.gov/regulations/ecomments

Re: Medicare Program; Provider Reimbursement Determinations and Appeals [CMS-1727-P]

Dear Dr. McClellan:

On behalf of our 4,700 member hospitals and health care systems and our 31,000 individual members, the American Hospital Association (AHA) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule concerning provider reimbursement determinations and appeals. We appreciate and generally support CMS' efforts to streamline the process for pursuing appeals that begin with the Provider Reimbursement Review Board (PRRB) or an intermediary hearing officer. In this comment letter, we offer recommendations that are in line with the agency's goal of improving the appeal process while also ensuring that hospitals have a full and fair opportunity to pursue Medicare reimbursement appeals.

Adding Issues to a Hearing Request ["Provider Hearing Rights" section]

We understand CMS' concern that the resolution of appeals to the PRRB could be delayed when providers add issues to existing appeals. However, we believe the agency's proposal is too constraining. Despite their best efforts, providers may not have the information needed to meet the proposed deadline for adding issues. It can take 180 days for providers to obtain the intermediary's audit workpapers or the work product from outside consultants needed to determine the merits of a new issue.

In our view, there are alternate deadlines for adding issues that would not delay a PRRB appeal. For example, allowing a provider to add issues to its preliminary position paper would offer time

to identify issues without delaying the appeal. In addition, we suggest that CMS provide the PRRB with the authority to extend the deadline for adding issues when it deems an extension to be appropriate. This is necessary to rectify situations in which the provider is not aware of an issue because the fiscal intermediary does not provide the necessary information prior to the deadline for adding issues.

Prompt Resolution of Clear Errors ["Board Proceedings Prior to Hearings" Section]

The current backlog of 10,000 cases at the PRRB must be reduced; we believe that a more aggressive approach to resolving issues that involve clear errors helps. A number of appeals to the PRRB relate to audit errors, clerical errors or other minor issues for which providers file what amounts to little more than "protective appeals." While CMS' proposal to require the provider and intermediary to attempt to resolve legal and factual issues would seem to be a mechanism to resolve these issues or errors, absent the involvement of the PRRB or its staff no such resolution occurs and the appeal drags on to a hearing. The AHA recommends that a mechanism be established by which a provider can identify issues that should be quickly resolvable and explain why they can be resolved quickly, followed by the PRRB or its staff convening a conference call to address such issues. In our view, bringing the parties together early in the appeal can eliminate some or all issues quickly, minimizing the burden on all involved.

Conclusion

Thank you for the opportunity to provide input as you finalize the provider determinations and appeals rule. We look forward to more efficient and expeditious provider appeals processes and hope that you consider our suggested changes as you move forward. If you have questions regarding our comments please feel free to contact me or Maureen D. Mudron, Washington counsel, at mmudron@aha.org or 202-626-2301.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : Mr. Roger Jansson **Date & Time:** 08/24/2004 12:08:00

Organization : Bennett Bigelow & Leedom, P.S.

Category : Attorney/Law Firm

Issue Areas/Comments

GENERAL

GENERAL

Please see attached MS Word document. (Our file No. mm429852.)

CMS-1727-P-32-Attach-1.doc

Bennett Bigelow & Leedom, P.S.
1700 Seventh Avenue, Suite 1900
Seattle, Washington 98101-1355

Telephone: (206) 622-5511
Facsimile: (206) 622-8986
Website: www.bbllaw.com

August 24, 2004

Comments on Proposed Rule, 69 Fed. Reg. 35716 (June 25, 2004) – File Code CMS-1727-P

Dear Sirs/Madams:

We write on behalf of our clients to submit comments to the above-noted proposed rule, entitled "Medicare Program; Provider Reimbursement Determinations and Appeals." Per your instructions, we submit our comments electronically to http://www.cms.hhs.gov/regulations/ecomments. Our comments are as follows.

(1) Provider Hearing Rights—Self-Disallowance Policy

CMS' proposal that providers must self-disallow an item by filing a cost report "under protest" is an invalid attempt to undermine the scope of authority established for the PRRB by Congress in the Medicare statute. The Supreme Court explicitly rejected this CMS position in *Bethesda Hospital Association v. Bowen* 485 U.S. 399 (1988), recognizing that the Medicare statute expressly authorizes the PRRB to adjudicate amounts and issues that providers have self-disallowed and, thus, which the intermediaries have not opined upon. In the proposed rule, CMS is attempting to rewrite Congress's express requirements, as interpreted by the Supreme Court, and is once again taking the position that, in order to preserve its appeal rights, a provider must either claim an item on its cost report, or self-disallow an item by filing a cost report "under protest." *See* 69 Fed. Reg. 35722, citing PRM-II (CMS Pub. 15-2), §115. This CMS position violates 42 U.S.C. §1395oo(a).

Bethesda held that the plain language of the dissatisfaction requirement in 42 U.S.C. §1395oo(a) grants a provider the right to obtain "a [PRRB] hearing with respect to [its] cost report" if the provider meets three jurisdictional prerequisites: (1) the provider "is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report"; (2) "the amount in controversy is $10,000 or more"; and (3) "such provider files a request for a hearing within 180 days." *Bethesda,* 485 U.S. at

403 (quoting 42 U.S.C. §1395oo(a)); *accord, French Hospital Medical Center v. Shalala*, 89 F.3d 1411, 1416, 1418 n.9 (9th Cir. 1996). The Supreme Court in *Bethesda* concludes that "[n]o statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary." *Id.* at 404. The Court recognized that it was futile to submit challenges based on regulations, statutes, or CMS's formal policies – all of which are binding on the intermediary and from which it cannot deviate – to the intermediary before invoking the PRRB's review. *See id.*

Moreover, in *Bethesda*, the Supreme Court found that "once jurisdiction has been invoked" over a cost report under 42 U.S.C. §1395oo(a), then §1395oo(d) "sets forth the powers and duties of the Board." 485 U.S. at 405; *accord, French Hospital*, 89 F.3d at 1418, and n.9. The Supreme Court expressly observed in *Bethesda* that the text of §1395oo(d) "allows the Board . . . to review and revise a cost report with respect to matters **not contested** before the fiscal intermediary." 485 U.S. at 406 (emphasis added). According to the Court, "the only limitation prescribed by Congress is that the matter must have been "covered by such cost report," meaning that **"a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed."** *Id.* (emphasis added). Thus, CMS's attempt to limit the scope of the PRRB's statutory authority to review all issues covered by any cost report over which it properly has jurisdiction exceeds CMS's legal authority.

Not only is this CMS proposal in direct violation of clear statutory authority, but it is also impracticable to expect providers to file "under protest" every potential item on their cost reports that may be disallowed under the applicable regulations or manual provisions. Providers are faced with overwhelming numbers of regulatory and policy manual issuances covering a complex array of constantly changing Medicare billing and documentation requirements. CMS's attempt to cut-off providers' appeals rights because they may not recognize the invalidity of a particular intermediary's interpretation of CMS's regulations and policies at the time of filing their cost report is without basis in law or equity. Such an approach would render useless many of the express protections created for providers by Congress in the Medicare statute's appeal provisions. Thus, we respectfully request that CMS reverse its self-disallowance policy in the proposed rule.

(2) Provider Hearing Rights—Audits of Self-Disallowed Items

CMS is also proposing to add a new paragraph (d) to §405.1803, which would authorize CMS to require intermediary audits of self-disallowed items before these items may be paid according to a final agency decision, a final non-appealable court judgment, or an administrative judicial settlement agreement. *See* 69 Fed. Reg. 35722. We believe this provision is unnecessary because CMS already reserves the right to, and routinely has its intermediaries perform additional auditing steps, before issuing an NPR as a result of a final agency determination. CMS's current regulatory and contractual

authority over its intermediaries, which act solely at CMS's instruction and as its agent, render additional regulatory provisions of this nature superfluous.

(3) Provider Hearing Rights—Contents of Hearing Request

CMS is also proposing "to require the provider to demonstrate in its hearing request (through argument and supporting documentation) that it meets the requirements for a hearing before the intermediary or the Board, respectively" and to "include a description of the nature and amount of each self-disallowed item and the reimbursement sought for each cost." 69 Fed. Reg. 35723. We believe that it is outside CMS's statutory authority to establish the requirements by which the PRRB will determine whether or not it has jurisdiction. Congress established the PRRB as an independent tribunal within HHS, not subject to CMS's direct oversight or control, permitting CMS only to review a final determination of the Board after it is issued. 42 U.S.C. § 1395oo. Under the Medicare statute, only the Board – not CMS – has "full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section." 42 U.S.C. § 1395oo(e).

The Board has historically had no difficulty establishing the necessary standards and guidelines governing provider appeals, and jurisdictional showings. *See Provider Reimbursement Review Board Instructions* (eff. Mar. 1, 2002). CMS's attempt to interfere in the establishment of those standards is simply an attempt to create additional technical barriers to provider appeal rights. If the Board believes that additional information should be required in a hearing appeal request, only it has the authority to establish those standards. 42 U.S.C. § 1395oo(e).

Finally, CMS attempts to codify, in the guise of a procedural regulation, a substantive change to provider appeal rights. CMS proposes to require the hearing request to include each intermediary determination at issue in the appeal, and "if the intermediary determination under appeal is a revised NPR, the provider would be required to include the pertinent reopening notice and the initial NPR so that an appropriate determination can be made as to whether a specific matter at issue is within the scope of the revised NPR." *Id*. As CMS is well-aware, its position that providers can only appeal issues that were actually adjusted in revised NPRs is not supported by case law in all jurisdictions, and is contrary to the *Edgewater* doctrine. *See, infra,* at (10).

When taken together, these new requirements governing the contents of hearing requests create significant new hurdles for Providers to jump over before filing an appeal, and make it much more difficult for providers to meet appeal deadlines. CMS has no statutory authority to impose its requirements on the PRRB's hearing process, and no authority to supercede in regulation those standards already established by the Board in accordance with its express statutory authority. CMS's

attempts to interfere with the Board's independence and procedures is an unlawful attempt to alter providers' procedural and substantive rights to review under the Medicare statute.

(4) Provider Hearing Rights—Adding Issues to Original Hearing Request

CMS proposes to revise the current regulations which allow providers to add issues to appeals at any time before commencement of the hearing. CMS proposes to allow providers to add issues only during the 60-day period commencing with the expiration of the 180-day period for submitting the original hearing request. *See* 69 Fed. Reg. 35724. CMS explains that this new restriction on adding issues is necessary because of the case backlog at the Board, because Board hearings often are not conducted until several years after the original hearing request, providing "a virtually open-ended period for adding issues." *Id.* CMS concludes that the proposed 60-day period to add issues to the original hearing request "gives the provider ample time to appeal any matter overlooked in the original hearing request." *Id.*

We acknowledge that hearings are often conducted years after the original hearing request, but we object to the short 60-day period to add issues proposed by CMS. Limiting the ability of the Board to entertain issues added by providers violates the statutory power of the Board:

> **The Board shall have the power** to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and **to make any other revisions on matters covered by the cost report** (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

42 U.S.C. §1395oo(d) (emphasis added). CMS does not have the statutory authority to limit the Board's power to revise any matter covered by a cost report under appeal, and it cannot make this substantive change under the guise of a procedural amendment. Even if CMS did have such power, we believe that that this 60-day period is far too short to allow providers to add issues to appeals, and we note that CMS provides no information as to how it determined 60 days to be an appropriate period. As noted above, if any limitation is to be imposed on providers' ability to add issues to an appeal pending before the PRRB, only the PRRB is authorized to establish such a limit.

CMS also argues that the Board's jurisdiction over appeals from revised NPRs (post-reopening appeals) is based on §405.1889 of the reopening regulations, and not on 42 U.S.C. §1395oo(d). *See* 69 Fed. Reg. 35724, citing *French Hosp. Med. Ctr. v. Shalala*, 89 F.3d 1411, 1416-20 (9th Cir. 1996); *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 617-619 (D.C. Cir. 1994). CMS therefore argues that the 60-day period for adding issues to post-reopening appeals of revised NPRs is not inconsistent with §1395oo(d). While it is true that §1395oo(d) does not explicitly mention revised

NPRs, the *Edgewater* doctrine relies in part on §1395oo(a) and §1395oo(d) to find that revised NPRs are "final determinations," and to allow Board jurisdiction over issues considered but not adjusted in appeals from revised NPRs. *See, infra,* at Section (10). As noted above, CMS has no legal authority to restrict the scope of Board authority established by Congress in the Medicare statute.

CMS states that it considered and rejected the alternative of eliminating altogether the opportunity to add issues, and CMS concluded that a provider "may reasonably need additional time to ensure its original hearing request is complete, and, if necessary, request addition of issues to the original request." 69 Fed. Reg. 35725. We believe that the 60-day period is in clear violation of 42 U.S.C. 1395oo(d) for appeals of original NPRs, and even if it is not in violation of the Act for appeals of revised NPRs, it is not a reasonable or sufficient time period to add issues to appeals. Any limitation on adding issues is solely with the purview of the Board.

(5) Provider Request for Extension

CMS proposes to limit provider requests for good cause extension of time period for requesting hearings to "extraordinary circumstances beyond its control (for example, natural or other catastrophe, fire, or strike)" and further proposes that such extensions beyond the usual 180-day period for hearing requests should never be allowed more than three years after the date of the intermediary determination. *See* 69 Fed. Reg. 35725. We believe that CMS is attempting to usurp the Board's discretion in determining whether there is good cause to grant an extension, and is setting the bar too high. As noted above, only the Board is authorized to establish the procedures and limitations governing its own independent review of provider appeals. There is no basis for CMS to interfere in that authority.

CMS also proposes to "prohibit the pertinent reviewing entity from granting a good cause extension request if the provider relies on a change (whether based on a court decision or otherwise) in the law, regulations, CMS Rulings, general CMS instructions, or CMS administrative ruling or policy as the basis for the extension request." 69 Fed. Reg. 35726. Once again, CMS is unnecessarily limiting the Board's authority to determine "good cause."

(6) Group Appeals

CMS proposes to revise the group appeal provisions of §405.1837(a) "to clarify that each provider in a group appeal must satisfy individually the requirements for a single provider appeal (except for the $10,000 amount in controversy requirement)." *See* 69 Fed. Reg. 35728. CMS first cites 42 U.S.C. §1395oo(b) as authorizing group appeals before the Board, but then states that providers in group appeals must satisfy individually the requirements for single provider appeals under 42 U.S.C. §1395oo(a) of the Act except for the $10,000 amount in controversy requirement.

See 69 Fed. Reg. 35727-28. We object to this new CMS proposed regulatory requirement for providers in group appeals to meet the requirements for single provider appeals because, again, it improperly interferes with the authority granted by Congress to the Board to establish the procedural requirements governing provider appeals. The Board is best situated to determine what modifications to its own group appeal instructions will promote efficiency, while not substantively disadvantaging provider rights. Congress had clear policy justifications for not authorizing CMS, which is the adverse party in provider appeals, to interfere in the Board's independence or authority.

(7) Expediting Judicial Review

Under the comment caption "*Expediting Judicial Review,*" there is also a section on "Parties to a Board Hearing" at 69 Fed. Reg. 35732. According to this proposal, CMS will be allowed to be "included in the hearing process without having formal party status." There is no basis for CMS to insert itself into the hearing process, unless it opens itself to all the obligations and responsibilities of any party thereto. Legally, CMS has no authority to intercede in PRRB hearings, while those are in process, unless it is a party to the process. CMS should not be permitted to pervert the independence of that process by interceding in provider hearings, without being obligated to comply with the obligations of a party thereto (such as responding to discovery requests).

CMS proposes to "add a new §405.1843(c) to authorize intermediaries to designate a representative from CMS, who may be an attorney, to defend the intermediary's position in proceedings before the Board." *Id.* CMS explains that it is modeling this revision on the provisions authorizing the DOJ to allow outside attorneys to appear on its behalf in certain situations under 28 U.S.C. § 515. The CMS proposal also permits CMS to make written and timely filed *amicus curiae* submissions for the Board's consideration. These proposals are not supported by statutory authority and are intended solely to interject the agency's influence in the PRRB hearing process, in advance of that time when CMS properly has authority to uphold, vacate, or modify a final PRRB determination.

We object to this CMS proposal that effectively allows CMS to weigh in on Board hearings without being designated as a party or a representative of the intermediary, and therefore weakens the independence of the Board hearing process. These proposed revisions increase the interference by CMS in Board hearings and decisions, which by statute are intended to serve as an independent tribunal. CMS's proposals in this regard are one-sided, by providing CMS influence on proceedings in which it refuses to participate as a party. CMS basically seeks to have the benefit of influencing the independent Board review process, without subjecting itself to any of the corresponding responsibilities attendant with being a party to those proceedings. If CMS is to participate in the proceedings, as proposed, it must be viewed as a party to the proceeding. In any event, as noted above, CMS has no statutory authority to insert itself into the PRRB process in the manner proposed.

(8) Board Proceedings Prior To Hearing

CMS proposes to remove the reference in §405.1853(a) that requires the provider and intermediary to submit position papers to the Board no later than 60 days after the provider's hearing request. *See* 69 Fed. Reg. 35733. CMS proposes that the Board will set deadlines for position papers on a case-by-case basis "as appropriate"—instead of using the standardized briefing timeline starting 60 days after hearing request. *Id.* We take issue with this change, because it reduces the certainty of timelines and critical due dates, making case management more complex for all parties involved. Further, as noted, above, only the Board has the authority to dictate the process for provider appeals before the Board.

CMS also proposes to revise the time limits for requesting discovery. *See* 69 Fed. Reg. 35733. Under the current regulations at §405.1853(b), the Board must allow all timely requests for pre-hearing discovery. CMS notes that this technically allows parties to file discovery requests as late as 1 day before the hearing, and argues that this is an unreasonable requirement in light of the current backlog of cases before the Board. CMS thus proposes that a party's discovery request is only timely if the date of receipt by another party or non-party is no later than 90 days before the scheduled hearing, and a party would not be permitted to conduct discovery any later than 45 days before the scheduled hearing. *Id.* CMS does allow the Board to extend the time for making discovery requests or performing discovery upon a showing of good cause. Given that CMS regularly refuses to respond to discovery requests, on the grounds that it is not a party to the PRRB proceeding, providers reasonably view these proposals as yet another attempt by CMS to restrict provider appeal rights through technicalities. Moreover, if any revisions are needed to the discovery process available during a PRRB appeal, those revisions should be established by the Board, as the independent tribunal with sole authority to maintain that independent process.

(9) Administrator Review

CMS proposes to add §405.1875(f)(5) to "specify that the Administrator has the authority to remand a matter not only to the Board, but also to any component of HHS or CMS, or to an intermediary, under appropriate circumstances (including, but not limited to the purpose of implementing a court's order." *See* 69 Fed. Reg. 35739. This provision is directly contrary to Congress' instructions in 42 U.S.C. § 1395oo(f), specifying that "[a] decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision." Congress did not authorize CMS to end-run the judicial review process by remanding issues ultimately decided by the PRRB to sub-components of HHS or CMS for further action. If the Administrator disagrees with the PRRB determination, he can take necessary action, without further delaying provider appeal rights. There is no need for the Administrator to remand to a lower component of his own agency to

obtain necessary input. This proposal is in excess of statutory authority and intended simply to end-run the statutory review process.

CMS also proposes to revise §405.1877(b) by adding (b)(3) to state that "an Administrator remand of a Board decision is not subject to judicial review." *Id.* This proposal is fundamentally inconsistent with Congress' instructions set forth in 42 U.S.C. § 1395oo, and is without legal support of any kind. This proposal is simply intended to delay indefinitely providers' judicial appeal rights and cannot withstand scrutiny. *See County of Los Angeles Dept. of Health Servs. v. Thompson,* 2001 U.S. Dist. LEXIS 24630 (D.D.C. 2001) (finding "[i]t is unnecessary to reach the thorny issue of whether the statute grants remand authority to the Administrator" and citing two cases more recent than *Gulf Coast* that hold that the Administrator lacks authority to remand: *Boulder Community Hosp. v. Heckler,* 1985 WL 81771 (D.D.C. Oct. 3, 1985) and *Lifemark Hosps. of Mo., Inc. v. Sullivan,* 1992 WL 159781 (W.D. Mo. April 2, 1992)).

(10) Reopening Procedures

Under the guise of "reopening procedures," CMS is directly attacking decisions by the PRRB and federal courts on the scope of jurisdiction over appeals of revised NPRs. As noted previously, CMS has no statutory authority to interfere with the PRRB review procedures and process, substantively or otherwise. CMS contends that its "longstanding policy" is "that a reopening of a determination by itself does not extend appeal rights, **and that any matter that is considered** during the course of a reopening (including a matter specifically identified in a notice of reopening) **but is not revised is not within the proper scope of an appeal of a revised determination or revision** (see §405.1889)." 69 Fed. Reg. 35741 (emphasis added). This policy is directly inconsistent with courts interpretations of provider appeal rights. CMS critiques *Edgewater Hospital v. Bowen,* 857 F.2d 1123 (7th Cir. 1989), the lead case allowing jurisdiction over issues "considered" but not revised by intermediaries in revised NPRs. CMS erroneously states that the *Edgewater* decision was based on the "clear language of the Regulations," and was therefore not based on statute. *Id.* CMS's attempts to overrule binding judicial precedent governing the scope of PRRB, and judicial, review is without legal authority.

The *Edgewater* court based its holding on the unanimous decision of the Supreme Court in *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988), which held that the PRRB has jurisdiction over claims that had not been included in an original cost report or had been self-disallowed by the provider in compliance with Medicare regulation or policy which the provider intended to challenge before the PRRB. *Edgewater,* 857 F.2d at 1132-1133.

We strenuously object to this new provision limiting the Board's statutorily-authorized jurisdiction over revised NPRs. While *Your Home* holds that the Board does not have discretion over

an intermediary's refusal to reopen a cost report, once the intermediary reopens a cost report in response to a provider's request for reopening, the Medicare statute treats the revised NPR as subject to the same scope of Board jurisdiction as an original NPR. *See, e.g.*, 42 U.S.C. § 1395oo(a), (d); *Edgewater*, 857 F.2d at 1136-37; *French Hospital Medical Center v. Shalala*, 89 F.3d 1411, 1420 (9th Cir. 1996).

In the proposed rule, CMS states that several courts have upheld its proposed changes that "the scope of appeal of a revised notice of amount of program reimbursement (NPR) or other revised determination or revised decision is limited to the specific revisions that were made in the revised determination or decision." 69 Fed. Reg. 35742. CMS then incorrectly cites to two federal decisions for the proposition that:

> [I]f the time to raise a matter through an appeal of the original determination or decision has expired, the matter may not be appealed through an appeal of a revised determination or decision if the matter has not been specifically revised in the revised determination or decision.

69 Fed. Reg. 35742, citing *Foothill Presbyterian Hosp. v. Shalala*, 152 F.3d 1132 (9th Cir. 1998); *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 618 (D.C.Cir. 1994). Contrary to this CMS citation to *HCA* in the proposed rule, the *HCA* court refused to rule on the question of whether a cost item must actually be revised or merely reconsidered in a Revised NPR in order to be appealable. *HCA*, 27 F.3d at 621. In addition, the *Foothill* court cited *French Hospital* and *Anaheim* positively, and as described above, both *French Hospital and Anaheim* adopt *Edgewater*. *Foothill*, 152 F.3d at 1135.

CMS is openly and improperly attempting to alter through regulations the scope of the PRRB's jurisdiction, as defined by the PRRB itself. In a 2000 PRRB decision, the PRRB distinguished an "intermediary-generated" reopening from a 'provider-requested' reopening and held that in the former "the principles in *Edgewater* . . . would not apply. *See Mercy General Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California*, PRRB Dec. No. 2000-D87, September 22, 2000, Medicare and Medicaid Guide (CCH) ¶80,572. Thus, the Board clearly is able to define the own scope of its jurisdiction, without interference by CMS.

* * * * *

We appreciate the opportunity to comment on the proposed revision of to various provisions of the regulations governing provider reimbursement determinations and appeals, on behalf of our

clients. Please contact us if you have any questions regarding our comments on the above-noted issues. Thank you very much.

Very truly yours,

BENNETT BIGELOW & LEEDOM, P.S.

Sanford E. Pitler
Lisa Dobson Gould
Roger L. Jansson

w:\wdclient\0220\00002\mm429852.doc

Submitter : Ms. Susan Johnson **Date & Time:** 08/24/2004 12:08:00

Organization : Iowa Health System

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

See attached file.

CMS-1727-P-33-Attach-1.doc

August 24, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1727-P
PO Box 8017
Baltimore, MD 21244-8017

Dear Sir or Madam:

I am responding to the June 25, 2004 Federal Register with proposed rules for Provider Reimbursement Determinations and Appeals. Overall, the proposed rules do a nice job of clarifying the appeals process. I have only one comment as follows:

Reopening Procedures

The proposed rules specify that an intermediary must issue a notice of reopening within three years of the notice of program reimbursement (NPR). My concern is that there are no timeliness requirements imposed on intermediaries which require them to actually process reopenings and issue a revised NPR. We currently have reopenings pending for fiscal years from the early nineties with no indication from the intermediary that the reopenings will be completed anytime soon. It is unreasonable to have reopenings pending for over one year. Provider and intermediary staff familiar with the reopening issues are frequently no longer available, creating additional work for both the provider and intermediary staff. I recommend that CMS require intermediaries to complete reopenings for intermediary- identified issues within one year of the date of the notice of reopening.

Thank you for the opportunity to comment and please contact me at (515) 241-6290 with any questions.

Sincerely,

Susan G. Johnson
Reimbursement Manager

Submitter : Mr. Del Nord **Date & Time:** 08/24/2004 12:08:00

Organization : Quality Reimbursement Associates

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

See attached

CMS-1727-P-34-Attach-1.doc

August 24, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1727-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: CMS-1727-P; Provider Hearing Rights

Dear CMS:

I am writing to comment on the proposed rules related to Medicare Provider Reimbursement and Appeals. The proposed rule was published in the Federal register on June 25, 2004. More specifically I wish to address my comments to the section on Provider Hearing Rights.

It has been proposed that providers will no longer be able to add issues to an existing open appeal after a 60 day period expires. The 60 day period is to begin with the expiration of the applicable 180-day period for submitting the original hearing request. The reason for imposing this limitation appears to stem from the Board's case backlog.

I do not agree that it is necessary to revise the regulations governing the addition of issues. As you noted in the background section of the proposed rules:

"In addition to the NPR, other determinations made by the intermediary or CMS for hospitals and other providers are appealable to the intermediary or Board (depending on the amount in controversy), such as: a denial of a hospital's request for an adjustment to, or an exemption from, the TEFRA rate of increase ceiling (see Sec 413.40); a denial of a HHA's or SNF's request for an adjustment to, or an exemption from, the routine cost limits that were in effect prior to a PPS for such providers (see Sec 413.30); a denial of a PPS hospital's request to be classified as a sole community hospital (see Sec 412.92) or rural referral center."

Provider's nowadays have no other reliable recourse to correct errors found in the cost report. Some Provider's are being subjected to Intermediary abuse in the wake of the Your Home decision. It has been my experience that some Intermediaries are abusing their powers and are refusing to evaluate the merits of the Provider's requests to reopen cost reports for clear and obvious errors.

For example I have experienced Intermediary denials of reopening requests to correct Medicare disproportionate share payments when: 1) Medicaid patient days were erroneously counted as Medicare Part A days (even when the FI was provided copies of paid Medicaid remittance advices and/or a copy of the common working file proving the patients were not entitled to Medicare Part A); 2) The state electronic verification system failed to count patient days for patients the State actually paid the claim

for (even when the FI was provided with copies of the paid remittance advices); 3) The State verification system fails to count newborns even though the mother of the newborn was counted (the Intermediary was provided documentation that the mother was counted yet the newborn had not been counted) and 4) Medicare Part A days were erroneously counted as Medicaid days by the State verification system.

Even decisions by hearing officers and the Board are subject to further review. As noted above other forms of denials can be appealed. I suggest that a FI's denial to reopen a cost report should also be subject to further review. Without this further review Intermediaries will continue to abuse Providers by refusing to reopen cost reports and correct clear and obvious errors.

With respect to the Board's case load I would like to suggest that the Your Home decision had something to do with the number of cases being filed. If a Provider knows that the FI can refuse to reopen their cost report and that they will have no recourse should this occur, then they also know that they would be best served by filing an appeal. It is the only sure way they have of getting the FI's attention to correct errors. Likewise if a Provider has been subjected to Intermediary abuse by way of an Intermediary denial of a legitimate reopening request, the Provider knows that they are wise to file an appeal for each and every cost reporting period. It is the only protection Providers have.

Three years are allowed to request or initiate a reopening in the event clear and obvious errors are discovered. Since 3 years are allowed for reopening activities it seems to follow that some problems and errors go unnoticed for a considerable amount of time. The very fact that numerous reopenings have been done supports the position that clear and obvious errors exist after NPRs are issued and these errors can go unnoticed for long periods of time.

Therefore, if you are unwilling or unable to allow Providers to appeal reopening denials, then I propose the limitation for adding issues to an open appeal should be set at 3 years. This would provide a means for CMS and Providers to ensure clear and obvious errors could be corrected.

Another thought I would like to share with you with respect to case load is that cases are resolved administratively once the FI is faced with a hearing date. We routinely provide FI's with documentation which is adequate to resolve the outstanding issues. My experience has been that the FI does not even consider or review this documentation until they are faced with a hearing date. I do not believe your proposal to require Providers to submit more documentation earlier in the process will have much of an impact with respect to relieving your case load. A more effective proposal might be to charge the FI interest from the time the Provider submits their final position paper until the time the case is resolved on the amount that is eventually paid to the Provider.

My final thought on the ability to add issues is this: Perhaps the regulation should be left alone and not changed. By allowing Provider's to add issues up until the date of the hearing an incentive is built in to the system for the Board (and to some extent for FI's as well) to resolve issues and cases as quickly as possible. Along the same line of thinking – if the FI were required to participate in the cost of issues that are later added to an appeal, they would have a strong incentive to correct errors and resolve cases quickly before other issues could be identified.

I disagree with the proposed rule that would require Provider's to identify self-disallowed issues as protested items. Providers have to trust the information they are provided with when preparing cost reports and follow the directions that have been issued. The people that prepare cost reports may not have the background, time or ability to evaluate or question whether the data they've been provided with from government sources or the instructions that have been issued should be challenged. This provision may put undo pressure on people that prepare cost reports, and could increase administrative costs as Providers seek professional help to identify issues that they may not be aware of. Provider's will have the incentive to question and appeal everything they can imagine in order to protect their facility in the event of some subsequent finding. Sometimes it takes a considerable amount of research and investigation into issues to discover that errors exist in the underlying government data that was used to prepare the cost report. Once this discovery is made it seems appropriate that the error be corrected and adjustments made. Providers should not be held responsible for discovering errors made on the part of government bodies.

As an example of a problem that could develop as a result of the proposed rule let's consider the SSI percentage. The correct SSI percentage generally has not even been determined when the cost report is prepared and filed. Providers often use a prior years SSI percentage and anticipate the FI will adjust it before finalizing the cost report. I have witnessed a number of cases where the FI failed to adjust the SSI percentage, and the SSI percentage was wrong. If the FI doesn't adjust the SSI percentage there is no adjustment to appeal. If the Provider fails to list this issue as a protested item, then how can the Provider establish appeal rights for this issue? If the FI were to refuse to reopen to correct this error what recourse would the provider have? If the Provider is unable to establish appeal rights in this kind of situation it would appear that the FI and CMS would actually have an incentive to not make this adjustment to the cost report whenever the SSI percentage increases.

Once again, I would encourage you to propose a rule that would allow Provider's to be able to appeal a FI's denial to reopen a cost report to correct clear and obvious errors. In the absence of such a rule Provider's should be allowed to continue adding issues to existing appeals.

Thank you for your consideration of my comments on CMS-1727-P.

Sincerely,

Delbert Nord
Associate
QUALITY REIMBURSEMENT SERVICES
Healthcare Consultants

Submitter : Mr. Christopher Klang **Date & Time:** 08/24/2004 12:08:00

Organization : Tarrant County Hospital District, dba JPS Health Network

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Provider Hearing Rights--
II. (D)(1) ways to obtain a Board hearing
-Need to add (iii) the intermediary's refusal to reopen based on material error when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.

II.(D)(1) filing a cost report under protest
-By requiring providers to follow procedures for filing a cost report under protest, this will create more administrative work for the providers and the FI because it has to be claimed and the impact mannually calculated. The FI must then manually review each protested tiem and decide to remove or allow. The FI's failure to do that would automatically reimbursem Providers

II.(D)(5) 60-day add issues period
-60-days is an unreasonable amount of time because it forces providers to appeal everything and then weed-out as appropriate, which creates more administrative work. Further, for reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 prior to hearing is more reasonable.

Submitter : Mr. Tim Garrett **Date & Time:** 08/24/2004 12:08:00

Organization : United Regional Health Care System

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

These Comments Pretain to the Proposed Changes in the CMS appeals process.
Calculating Time Periods
II.(B)(2)(a) the expiration of the 12-month period for issuance of the NPR
-Restriction is not logical, and only creates more confusion. Under this proposed change, the Provider could only appeal Self-Disallowed items because how will it know what the FI is going to audit.

Provider Hearing Rights
II.(D)(1) ways to obtain a Board hearing
-Need to add (iii) the Intermediary.s refusal to reopen based on material errors when the rules and regulations require them to do so. A reopening may be refused because of a personal bias of the intermediary even when a material error exists.
II.(D)(1) filing a cost report under protest
-By requiring Providers to follow procedures for filing a cost report under protest, this will create more administrative work for the hospitals and the FI because it has to be claimed and the impact manually calculated. The FI then must manually review each protested item and decide to remove or allow. The FI.s failure to do that would automatically reimburse Providers.
II.(D)(3) the expiration of the 12-month period for issuance of the NPR
-Refer to comments under II.(B)(2)(a)
II.(D)(4) hearing request to include a description of each self-disallowed item
-Refer to comments under II.(D)(1)
II.(D)(5) 60-day add issues period
-60 days is an unreasonable amount of time because it forces people to appeal everything and then weed out as appropriate, which creates more administrative work. Further for Reopenings that are not settled, it forces reopening issues to be funneled to appeals to make sure rights are protected. 90 days prior to hearing is more reasonable.

II.(M)
-The Board should have to obtain the approval of the Provider or the Intermediary before assigning less than a quorum to conduct a hearing because some of the issues may be highly technical, and if a member is not there, just reviewing the written record may not enough to render an appropriate decision.

Board Proceedings Prior To Hearing
II.(N)
1. The Board should not have the authority to arbitrarily remove the reference to the 60-day timeframe, or set the deadlines for submitting position papers on a case-by-case basis as the Board deems appropriate because there would be no consistency.
2. We disagree with the method of discovery, the limiting of interrogatories and depositions. Specifically the section, which states .A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition.. It is likely that a party would never agree, so there needs to be a rule that in certain cases a party must agree to a deposition.
3. We disagree that a party.s discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days prior to hearing. We believe that a more timely date of receipt should no later than 60 days. Also, we feel that allowing a party to conduct discovery up to 45 days before the scheduled starting date of the Board hearing is in excess. Allowing 30 days for discovery is adequate.
4. In addition, we feel that limiting the duration of an automatic stay to no more than 15 days for Board Proceedings and to no more than 10 days for Intermediary hearing officer(s) proceedings is too strict. Creating limits of no more than 30 days for Board Proceedings and no more than 15 days for Intermediary hearing officer(s) proceedings would be more effective.

II.(O) time limits for requesting subpoenas
-Refer to comment number 3 under II.(N).

II.(P) Administrator excluding or including evidence not in the record.
-The Administrator should only be able to rule on the record because it is what the Board based its decision on, and it is the only thing a court of law may use to overturn a Board/Administrator decision.