Dennis Barry's
Reimbursement Advisor

ASPEN PUBLISHERS

SEPTEMBER 2010 • VOLUME 26, NO. 1
EDITOR: DENNIS BARRY

PRRB to Review Florida PIP Providers' Appeal

Board rules it has jurisdiction to review CMS' reopening of untimely RAC denials

By Joanne B. Erde and Christopher L. Crosswhite

The recovery audit contractor (RAC) demonstration program engaged in post-payment reviews of Medicare claims for the specific purpose of determining whether claims were paid in error and recouping the alleged overpayments. Not surprisingly, the RACs approached this task aggressively and alleged that there were massive overpayments that had to be recouped.

Although the RAC demonstration program began in 2005, the Florida RAC, for reasons that are not clear, did not start reviewing hospital claims until the demonstration program was almost half over. As a result, claims for services rendered during hospitals' 2002 through 2004 cost reporting periods were reviewed by the RAC in 2007 and 2008, so that it was reviewing claims that had been paid four and five years prior to review.

This delay in commencing the review of these claims violated reopening time limits. First, the delay resulted in violations of the basic time limits for reopening determinations on individual claims. Second, for hospitals that were paid on the periodic interim payment (PIP) basis, the timing of these overpayment determinations resulted in recoupment demands that also fell outside of the three-year limit for reopening cost reports and revising the final reconciliation of payments under PIP. [*See* 42 C.F.R. §§ 412.116(b), 413.64(h)c.]

CMS Disregard of Reopening Safeguards

The Centers for Medicare and Medicaid Services (CMS), however, was undeterred by these time limit violations. In fact, one of the hallmarks of the RAC demonstration program was CMS' wholesale disregard for some of the most basic procedural safeguards that providers have enjoyed through the years.

On the claims review side, the vast majority of the procedural problems related to the consistent failure to follow the well-established limitations on reopening of determinations on individual claims. Specifically:

- The four-year limit on reopening of such determinations unless there is fraud or similar fault was diminished by CMS' failure to specifically identify when the reopening occurred for claims reviewed by the RAC and

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what documentation was necessary to initiate the reopening. [*See* 42 C.F.R. § 405.980(b).]

- Similarly, the limit on reopening between one and four years after the initial determination, which requires a showing of good cause, was essentially disregarded—the RACs had no good cause under the standards existing at that time and CMS maintained that there was no jurisdiction to challenge the determination as to whether there was good cause. [*See* 42 C.F.R. §§ 405.980(b), 405.986.]

On the cost report side, the Medicare program's actions were equally egregious. CMS merely decided to ignore the three-year limit on reopening cost reports to recover the alleged RAC overpayments from PIP providers. [*See* 42 C.F.R. § 405.1885(b).]

PIP Versus Non-PIP Providers

The cost report reopening issue arose because of the different treatment that was afforded to PIP and non-PIP providers. Specifically:

- For non-PIP providers, the alleged RAC overpayments were recouped by the fiscal intermediaries contemporaneous with the determination of the overpayment.

- For PIP providers, although a remittance advice was sent contemporaneous with the determination of any alleged overpayment, no monies were recouped. When the RAC demonstration program ended in March 2008, CMS realized that there had been no recovery of the alleged overpayments from the PIP providers. As a result, in January 2009, CMS issued a joint signature memorandum (JSM) directing fiscal intermediaries to aggregate the outstanding RAC overpayments at PIP providers and issue demand letters to recoup the unrecovered overpayments.

CMS appears to have neglected to consider that the only way to adjust PIP payments after settlement of the cost report was through a cost report reopening. [Payment under PIP requires reconciliation of payments made during the fiscal year with the total reimbursement due the provider for the year through the cost report process. *See* 59 *Federal Register* 36707, 36708 (July 19, 1994).] And, in these instances, many of the notices of program reimbursement (NPRs) for the earlier fiscal years were beyond the three-year reopening period. Despite the fact that the reopening periods were closed, the first demand letters were sent to most PIP providers in April 2009.

Sometime after the letters were sent, CMS realized that for some fiscal years for which recoupment was demanded, the NPRs had been issued more than three years before the date of the demand letter, but that for other fiscal years, the three-year reopening period had not expired and these years could be reopened. As a result, CMS reconsidered its position, hedged its bets, and decided to treat the closed years differently than the fiscal years that were still within the three-year reopening period. CMS:

- Directed the fiscal intermediaries to send revised demand letters that demanded repayment only for fiscal years that were beyond the three-year reopening period; and

- Elected to follow the normal cost report reopening rules for those fiscal years that were within the three-year period.

Revised demand letters were sent to most PIP providers in May 2009, which reflected CMS' new position; the revised letters demanded repayment only for years that were closed. CMS was undeterred by the fact that it was too late to reopen these earlier cost reports and recoup the alleged overpayments in accordance with the well-established Medicare regulations regarding the finality of cost reports. The fiscal intermediaries recouped the monies demanded and several Florida PIP providers appealed to the Provider Reimbursement Review Board (PRRB). [Duane Morris 2002/2003/2004 RAC PIP Group, PRRB Case No. 09-1995G.]

PRRB Response

Once the appeal was filed, the PRRB, on its own motion, questioned whether it had jurisdiction to hear the case and requested jurisdictional briefs from the parties. Specifically, the board was concerned as to whether:

1. The appeal was a dispute over claims determinations, an issue over which the board does not have jurisdiction; and

2. There was, in fact, a reopening of the cost reports at all, since there was no action taken

by the intermediary that was identified as a reopening.

A highlight of the fiscal intermediary's argument in its jurisdictional brief was that the three-year limit on reopening was merely "the more conventional reopening process." The intermediary further asserted that this conventional process was "[o]bviously . . . a less contentious approach."

The intermediary appeared to be suggesting that there was some other less conventional reopening process that permitted CMS to make an adjustment to the PIP payment more than three years after the NPR was issued. The board did not accept this argument.

In fact, the PRRB concluded that this was not a dispute over claims determinations and the demand for repayment was a de facto reopening. As such, the board found that it had jurisdiction over the appeal, as follows:

1. The April 2009 demand letter to each provider for repayment of the overpayment was a final determination that was, in fact, a reopening of each provider's cost report. For providers that are reimbursed based upon PIP, there is no other way to adjust payments without reopening the cost report after the NPR is issued. Thus, the board has jurisdiction over the issue of whether this de facto reopening was proper.

2. The PRRB also found that the JSM setting out the "demand letter" for recoupment of PIP payments after the cost report has been finalized was contrary to the regulation and manuals and was not a proper method to implement policy changes.

In Summary

Position papers on this issue will be submitted to the PRRB in the fall of 2010. It appears, however, that by winning the jurisdictional issue, the providers essentially have won the substantive issue before the board as well.

Once it was determined for purposes of jurisdiction that the demand for recoupment was a de facto reopening of the cost report, which occurred more than three years from the date of the NPR, there appear to be no further bases on which CMS could prevail. There was no statutory authority granted in the RAC demonstration program that would in any way suspend the otherwise existing Medicare rules and regulations.

In fact, the statement of work for the RAC demonstration program specifically mandated compliance with all existing program rules and regulations. As such, it is too late for CMS to make an adjustment to the providers' PIP payments to recoup the alleged overpayments for fiscal periods beyond the three-year reopening period. The premise of the jurisdictional decision—the reconciliation of PIP payments through the cost report process—is one and the same with the merits of the case. ■

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