PRRB Issues New Procedural Rules

The Provider Reimbursement Review Board (PRRB), which hears Medicare Part A appeals, has issued a substantially revised version of its Instructions. These Instructions, which are effective as of March 1, 2002, set forth procedural rules for pursuing appeals before the PRRB. Failure to strictly comply with these Instructions may result in dismissal of appeals.

The Instructions contain several significant new requirements for individual hospital appeals, including the following:

1. Initial appeal requests must be very specific about the issue being appealed. In an example given in the Instructions, it is not sufficient to send in a general appeal about disproportionate share (DSH) payments. The specific aspect of the DSH calculation that is being appealed must be identified.

2. Initial appeal requests must include “a calculation demonstrating how your appeal meets the amount in controversy threshold.” It is not at all clear how detailed this calculation must be.

3. Initial appeal requests must specify the basis for contending that the Intermediary’s position on each issue appealed is incorrect. It is not clear how detailed the legal justification for each issue must be. PRRB staff has suggested informally that a law, regulation, manual provision, etc. supporting the provider’s position on each issue should be cited.

4. If there is no intermediary adjustment associated with an issue being appealed, and the provider is basing its appeal rights on a self-disallowance of costs pursuant to Bethesda Hospital Association v. Bowen (485 U.S. 399 (1988)), the provider must “identify the specific law, regulation, CMS (Centers for Medicare & Medicaid Services) Ruling or manual instruction that precludes an intermediary from reimbursing the cost.”

5. Pursuant to Medicare regulations, a provider may add issues to its appeals up until the time of hearing. However, the PRRB has indicated in its new Instructions that it will “look with disfavor” on issues added “at the last minute.” Further, the PRRB “encourages” a supplemental position paper on added issues at least 45 days prior to the hearing.

6. The PRRB will dismiss appeals if it is not provided with the required documentation to show that a preliminary position paper has been submitted to the intermediary by the required date. This represents a shift in policy; previously, the PRRB generally only dismissed appeals when the final position paper was not submitted on time.

The Instructions also make significant changes to the procedures for pursuing group appeals. These changes will be of particular significance to chain organizations that must pursue common issues in one appeal for all of their providers (referred to as CIRP...
appeals). The Instructions require
that group appeals be closed as of
12 months after the initial hearing
request, with position papers due
shortly thereafter. CIRP Providers
that have not yet received Notices
of Amount of Program Reim-
bursement (NPR), and whose ap-
peals have thus not yet become
ripe, must be identified on a sepa-
rate schedule. When those
providers finally receive their
NPRs, they must file separate ap-
peals and the PRRB will “notify
the provider whether [it] proposes
to treat it as part of the group ap-
peal and apply the group decision
to it.” These new provisions are
particularly puzzling, both as to
how the PRRB has the authority
to issue such rules and exactly how
they will work in practice. Signifi-
cantly, it is entirely unclear what
happens with respect to a federal
court appeal (or decision) should
the PRRB or CMS Administrator
issue a decision prior to the inclu-
sion of all CIRP group members.

The foregoing is only a brief
summary of some of the notable
new provisions in the Instructions.
Providers planning to pursue
PRRB appeals should read the en-
tire set of Instructions, which
should be available on the internet

Correspondence recently sent
by the PRRB to providers and
provider representatives stated that
the revised Instructions were appli-
cable only for appeals filed on or
after March 1, 2002. Contrary to
this, the Instructions themselves
indicate that this statement was er-
roneous, and that the new rules are
in effect as of March 1, 2002 for all
pending appeals as well. Further,
technical problems delayed the
posting of the Instructions on the
CMS website, so the PRRB has
informally indicated that there will
be a “grace period” before the new
rules will be enforced. In addition,
PRRB staff has indicated that the
strict new deadlines for group ap-
peals will only apply at first to
newly filed group appeals; dead-
lines for moving existing group ap-
peals forward will be imposed on a
rolling basis.

For additional information re-
garding the new instructions, please
call Byron Gross or Jon Neustadter at
310-551-8111.

NAMM Acquires
Seven IPA Contracts

North American Medical
Management of California
(NAMM) has completed its acqui-
sition of seven IPA management
contracts from Cerritos-based
Medical Pathways Management
Corporation.

“This acquisition has made
NAMM the second largest physi-
cian management organization in
the state, behind Kaiser Perma-
nente,” said HLB attorney Angela
A. Mickelson, who represented
NAMM in the transaction. “It al-
 lows NAMM to expand its market
from San Bernardino and River-
side Counties to Los Angeles and
Orange Counties.”

NAMM is an affiliate of Phy-
cor, which filed Chapter 11 bank-
ruptcy recently. NAMM and other
California affiliates of PhyCor were
not included in the bankruptcy fil-
ing, Ms. Mickelson noted.

“This was a complex transac-
tion with numerous moving parts,”
she said, adding that it required
bringing several parties together
and obtaining agreement from
each of the IPAs involved.

In a statement, NAMM noted
that despite current doubts about the
viability of physician practice man-
agement organizations, NAMM is
in a strong position to be successful
in this business, particularly given
the experience and commitment of
its employees and leadership.

Financial details of the acquisi-
tion and the names of the IPAs
involved have not been disclosed.

For more information, please
contact Ms. Mickelson at (310) 551-
8170.

OIG Calls for
Tighter Oversight
of ASCs

While ambulatory surgical
centers (ASCs) are experiencing
explosive growth, the Medicare
program is not up to the task of
providing quality oversight, ac-
cording to three reports recently is-
sued by the Health and Human
Services Office of Inspector Gen-
eral (OIG) devised to assess how
state agencies and accreditors over-
see ASCs and how the federal gov-
ernment holds them accountable.

The reports are titled: Quality
Oversight of Ambulatory Surgical
Centers: A System in Neglect; The
Role of Certification and Accredi-
tation; and Holding State Agencies and
Accreditors Accountable.

According to OIG, in 2000
Medicare paid $1.6 billion for 4.3
million procedures performed by
3,000 ASCs. ASCs are freestand-
ing facilities that may only bill
Medicare for surgical procedures
that the Centers for Medicare and
Medicaid Services (CMS) has de-
termined can be performed safely
outside of a hospital setting. ASCs
must become Medicare certified by
a state survey and certification
agency or privately accredited to
show that they meet the conditions
of participation. According to
OIG, the overwhelming majority
of ASCs choose to become Medicare certified by state agencies.

While ambulatory surgery has been shown to have good outcomes, according to the report, routine procedures have resulted in serious complications and death. Examples cited included a patient who died from complications in an ASC after undergoing a routine gynecological procedure, a patient whose bladder was perforated during surgery and transported bleeding to the nearest emergency room, and a patient who went into cardiac arrest and died during a cataract extraction.

ASCs more than doubled in number between 1990 and 2000, and the number of procedures increased by 730 percent from 12,000 to more than 101,000 procedures, according to OIG. In the midst of this explosive growth, CMS has done little to hold state certification agencies and accreditors accountable to the Medicare program and the public, the report noted.

Among the reports' other findings:

❖ Nearly a third of ASCs certified by state agencies have not been recertified in five or more years. Accredited ASCs are surveyed at least every three years, the report noted, but the survey process devotes less attention to verifying compliance.

❖ CMS does little to monitor the performance of state agencies regarding ASCs.

❖ With little performance monitoring, CMS has little on which to base meaningful feedback to state agencies and accreditors, the report said, noting that routine, operational feedback to state agencies and accreditors is problematic, since policy emerges from one of several units within CMS.

Regarding accountability to the public, the reports found that:

❖ Survey results are not readily accessible. CMS does not publish the results of state agency surveys on the Medicare website, the Medicare telephone hotline or on-site at ASCs. Only one accreditor releases accreditation survey results to the public.

❖ State agency certification and accreditation provide few meaningful insights for comparing ASCs. State agency survey reports lack comparative information on ASCs' performance relative to their past or their peers, the reports noted. Only one accreditor provides such information.

❖ Complaint processes have limited accessibility.

❖ CMS makes no information available on the performance of state agencies and accreditors.

Regarding certification, the reports found that:

❖ State agency certification allows many ASCs to fall through the cracks. In addition to expanding times between certifications, nearly half of complaints against ASCs certified by state agencies remain unresolved—some for as long as five years, the reports noted, adding that ASCs consistently rank near the bottom of CMS' survey budget priorities.

❖ Conditions of coverage fall short. The conditions have not been updated since 1982, the report noted, and they fail to distinguish among ASCs performing surgery of varying risks and complexities.

❖ State agency surveys focus entirely on compliance and fail to include continuous quality improvement. The surveys focus on gathering evidence to verify compliance with the conditions and do little toward improving the quality of ASCs beyond enforcing minimum requirements.

Regarding accreditation, the reports found that:

❖ Accreditation does provide a regular presence in ASCs. Each of the accreditors has policies to survey ASCs every three years and ASCs expect on-site presence at regular intervals.

❖ Accreditors update their standards regularly and adjust them to match the levels of surgery performed by individual ASCs.

❖ Accreditation surveys focus on helping ASCs continuously improve, but pay less attention to verifying compliance.

As a result of its findings OIG made a number of recommendations, including:

❖ CMS should hold state agencies and accreditors fully accountable to the Medicare program. Specifically, CMS should increase performance monitoring and use it as the basis of feedback to state agencies and accreditors.

❖ CMS should do more to hold state agencies and accreditors accountable to the public.

❖ CMS should determine an appropriate minimum cycle for surveying ASCs certified by state agencies.
CMS should update the Medicare Conditions of Coverage for ASCs.

CMS should ensure that state agency certification and accreditation strike an appropriate balance between compliance and continuous quality improvement.

CMS should hold state agencies and accreditors fully accountable to the Medicare program and to the public, for their performance overseeing ASCs.

It is clear from the OIG’s reports that ASCs can expect greater scrutiny and regulation in the future.

For information on the potential effects of these reports, please contact David Henninger or Robert Valencia at (310) 551-8111.

CALENDAR

March 21 HLB Attorney Pamela Riley speaks on HIPPA at the Medical Group Management Association Northern California Chapter Meeting, Clarion Hotel, San Francisco.

April 3-5 HLB Attorneys Patric Hooper, John Hellow and Jon Neustadter speak at the American Health Lawyers Association Institute on Medicare and Medicaid Payment issues, to be held at the Baltimore Marriot Waterfront. Topics of the course will be the Fundamentals of Medicaid Payment, Disproportionate Share Hospital Payments, and PRRB practice issues.

May 3-5 HLB Attorney Robert Lundy chairs the California Society of Healthcare Attorneys conference at the Grand Hyatt, San Francisco. HLB Attorney Patric Hooper speaks on Medicare/Medi-Cal Fraud.