The Law Offices of
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# Top Appeal Issues and Success Rates at the Provider Reimbursement Review Board

**In This Issue:**



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Hospitals and other Medicare providers continue to face cost report adjustments that deny reimbursement for a wide variety of items. However, certain issues are appealed more often than others. We analyzed all of the decisions issued by the Provider Reimbursement Review Board (PRRB) over the past two years. The PRRB is an independent panel that hears Medicare provider appeals of cost report determinations by payment contractors, including Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (MACs), as well as the Centers for Medicaid & Medicare Services (CMS).[1] As long as certain jurisdictional requirements are met, the PRRB is authorized to hear a broad range of provider appeal issues.[2] However, we found that a handful of issues dominate the PRRB's caseload, including: (1) Disproportionate Share Hospitals (DSH), (2) Direct Graduate Medical Education (GME) and Indirect Medical Education (IME), (3) Bad Debts, and (4) Wage Index/Rural Floor/Budget Neutrality. By examining PRRB decisions between October 10, 2010 and September 25, 2012, we identified a number of trends with regard to these frequently appealed reimbursement issues and their success rates.

Please feel free to reach us at the phone number or email address to the left if you have questions about these Medicare appeal issues or for assistance in appealing reimbursement issues to the PRRB.

**Disproportionate Share Hospitals.** Under the reimbursement rules for inpatient hospital services under Medicare Part A, the Medicare program adjusts payments higher for hospitals that serve a significantly disproportionate number of low-income patients.[3] These hospitals, referred to as DSH hospitals, receive a percentage add-on to their basic diagnosis-related group (DRG) payment amount under the Inpatient Prospective Payment System (IPPS).[4] The primary method by which hospitals qualify for the Medicare DSH adjustment is based on the following fractional calculation called the disproportionate patient percentage (DPP):

$$DPP = \frac{\text{Medicare/Supplemental Security Income Days}}{\text{Total Medicare Days}} + \frac{\textit{Medicaid/Non-Medicare Days}}{\textit{Total Patient Days}}$$

Although CMS ultimately calculates and applies the DPP, FIs and MACs are responsible for determining the factors identified above as *Medicaid/Non-Medicare Days* and *Total Patient Days*.[5] The *Medicaid/Non-Medicare Days* numerator represents the number of a hospital's patient days for which

patients were (i) eligible for care under a Medicaid State plan approved under Title XIX, (ii) not entitled to Medicare Part A (although patient days that are not covered under Part A or after Part A benefits exhaust *are* included), or (iii) authorized under a waiver pursuant to section 1115 of the Social Security Act (SSA).[6] Together with the *Total Patient Days* denominator, this portion of the DPP calculation is referred to as the Medicaid fraction and represents one of the issues most frequently appealed to the PRRB. So-called "Pickle" hospitals qualify for a DSH adjustment under an alternative method.[7]

Of the seventy-two PRRB cases decided between October 10, 2010 and September 25, 2012, eighteen of the cases involved a DSH appeal of an intermediary's Medicaid fraction determination. Within this subset, nearly all of the appeals specifically challenged an intermediary's *Medicaid/Non-Medicare Days* calculation.[8] Hospitals unsatisfied with their Medicare DSH determination argue that the intermediary erred by improperly excluding certain patient types from the Medicaid fraction numerator. Medicare Advantage and various state charity and indigency programs make up the majority of excluded patient types involved in these appeals.

Overall, providers prevailed before the PRRB in slightly over half of DSH cases considered—receiving favorable decisions in ten of eighteen determinations. However, a closer look at the decisions reveals that providers tend to prevail when arguing for the inclusion of Medicare Advantage days and tend to lose when arguing for the inclusion of various state indigency program days. Regarding Medicare Advantage days, in light of these decisions and guidance perceived as unclear, CMS has more recently amended the regulation to clarify its position, announcing that Medicare Advantage days are to be calculated in the *Medicare* fraction, not the *Medicaid* fraction.[9]

**Direct Graduate Medical Education and Indirect Medical Education.** In an effort to offset the costs incurred by hospitals that engage in medical education, the Medicare program makes two types of payments to teaching hospitals. The first, known as the direct graduate medical education payment (GME or DGME), compensates hospitals for the "direct" costs associated with a teaching program—*e.g.,* residents' salaries and fringe benefits, teaching physicians' salaries and fringe benefits, and other administrative costs associated with running the program.[10] GME payments are paid outside of the IPPS as a "pass-through," and the amount is calculated by multiplying the hospital-specific per resident amount (PRA) by a full-time equivalent (FTE) resident count and the hospital Medicare patient load.[11] The second type of medical education payment is for indirect medical education (IME), which helps compensate teaching hospitals for patient care costs that are generally higher than non-teaching hospitals by adjusting a hospital's DRG payment based on the number of interns and residents in relation to the total number of beds.[12] Both the GME and IME calculations rely on values determined by FIs and MACs. Therefore, providers frequently appeal unfavorable determinations to the PRRB.

Of the seventy-two PRRB cases decided between October 10, 2010 and September 25, 2012, fourteen of the cases involved an intermediary's GME or IME determination. Although the most recent GME/IME appeals deal with an intermediary's calculation of the hospital specific FTE resident count, other appeals have raised issues with the establishment of new residency programs and determinations of resident research time. During this roughly two year span, provider success has been varied—four decisions were fully favorable,

three decisions were partially favorable, and seven decisions were unfavorable. Of the four decisions regarding an intermediary's determination of the FTE resident count, only one was favorable to the provider. Similarly, challenges to the intermediary's determination on the establishment of a new medical residency training program were unsuccessful in two PRRB decisions.

**Bad Debts.** To help offset the burden of unpaid and uncollected medical bills, Medicare allows for the reimbursement of uncollectible "bad debts" outside of the prospective payment systems. As dictated by regulation, a provider is entitled to claim reimbursement for uncollectible accounts where: (1) the debt is related to covered services and derived from deductible and coinsurance amounts; (2) the provider can establish that reasonable collection efforts were made; (3) the debt is actually uncollectible; and (4) sound business judgment established no likelihood of recovery.[13] Not surprisingly, phrases in the regulatory criteria such as "reasonable collection efforts" and "actually uncollectible" often lead to conflict between providers and intermediaries regarding reimbursable bad debt. Additional collection efforts apply under Medicare's so-called "must-bill policy" for the approximately 20% of Medicare beneficiaries that are also eligible for Medicaid (*i.e.*, "dual eligibles"). Currently, Medicare reimburses hospitals for 70% of their Medicare bad debts, although this percentage is often debated by Congress and has fluctuated since 1997. Bad debt reimbursement is an important source of revenue for Medicare participating providers. As a cost-based reimbursable item, intermediaries frequently focus on bad debts during cost report reviews and deny such amounts using narrow interpretations of the regulation. This has resulted in frequent appeals to the PRRB.

Of the seventy-two PRRB cases decided between October 10, 2010 and September 25, 2012, seven of the cases involved appeal of an intermediary's bad debt determination. Providers have been consistently successful in appealing bad debt issues before the PRRB, losing only one of the seven appeals during this timeframe. The sole decision in which the PRRB affirmed an intermediary's denial of bad debt reimbursement involved a provider that failed to provide any data or documentation in support of the claimed bad debts. Where providers have preserved and been able to offer sufficient documentation of bad debt amounts and collection efforts, the PRRB has consistently held in favor of the provider. For example, in three appeals the PRRB reversed an intermediary's disallowance of a provider's claimed Medicare bad debts because the accounts related to the debts were still pending at outside collection agencies. Providers have been similarly successful in challenging intermediaries' assertions of insufficient bad debt collection practices. In both challenges before the PRRB dealing with this issue the board reversed the intermediary, instead affirming the adequacy of the providers' debt collection efforts. Similarly, the PRRB has repeatedly found that the "must-bill policy" for dual eligibles has no basis in regulation. This is particularly true for providers that do not participate in Medicaid.

**Wage Index/Rural Floor/Budget Neutrality.** Under the Medicare prospective payment systems, hospitals are reimbursed for operating and capital costs based on predetermined rates using average hospital costs. These costs are divided into a labor related portion and a non-labor related portion. In determining reimbursement for labor related costs, CMS adjusts the prospective payment rate by an index of relative labor costs known as the "wage index." Calculated annually from a survey of wage-related cost report data, the wage index is set for each geographic area classified as a Core-Based Statistical Area (CBSA) (formerly, Metropolitan Statistical Area (MSA))

and for each statewide area that is not within an MSA—*i.e.*, rural areas.[14] Hospitals within a particular MSA or rural area are reimbursed according to that wage index.

Hospital wage index calculations are affected by two additional factors: (1) the wage index floor (or "rural floor"), and (2) budget neutrality for the rural floor. Implemented as part of the Balance Budget Act of 1997 (BBA), the rural floor provision dictates that the area wage index of any hospital within a MSA cannot be lower than the area wage index applicable to hospitals located in rural areas of the same State.[15] Although modified since its inception, the rural floor provision has outlasted scheduled expirations and remains an important element of wage index calculation. If a provider disagrees with the accuracy of the wage data that CMS uses to determine its wage index, it may request that the data be corrected and the wage index recomputed. Likewise, the mandate of budget neutrality for the rural floor has had a direct impact on wage index calculation. The rural floor is applied in a budget neutral manner so that aggregate IPPS payments each year are not greater or less than would occur without the rural floor provision. Under the 2010 health care reform law, this is accomplished by returning to a uniform, national adjustment to the area wage index[16]—a provision that has been heavily criticized for favoring Massachusetts hospitals at the expense of hospitals in every other State. In addition, CMS recently settled a few cases challenging the budget neutrality adjustment by recalculating the adjustment factors for FYs 1999 through 2011.[17] Other pending appeals may be settled.

Recent appeal decisions by the PRRB on wage related costs used to calculate the wage index have been mixed. Of the four wage index cases decided between October 10, 2010 and September 25, 2012, the intermediary's adjustments were fully affirmed in one case, partially upheld in two cases, and reversed in one case. However, there are far more cases pending at the PRRB on other wage index issues, including the rural floor and budget neutrality factors, that are poised for more favorable success rates.

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Although the success rates in previous PRRB appeals cannot accurately predict future results, they provide a good indication of how the PRRB will address new cases. This can be helpful in weighing the merits of new and pending Medicare appeals on these issues.

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[1] *See* 42 U.S.C. § 1395oo; 42 C.F.R. § 405.1801 *et seq.*
[2] *See id*.
[3] *See* 42 C.F.R. § 412.106.
[4] *See* § 412.106(d)(2).
[5] *See* § 412.106(b)(4).
[6] *Id*.
[7] *See* SSA § 1886(d)(5)(F)(i)(II).
[8] 42 C.F.R. § 412.106(b)(4).
[9] *See* § 412.106(b)(2)(i)(B),(iii)(B); 75 Fed. Reg. 50,042, 50,285 (Aug. 16, 2010).
[10] *See* 42 C.F.R. § 413.76.
[11] *Id*.
[12] *See* 42 C.F.R. § 412.105.
[13] *See* 42 C.F.R. § 413.89(e).
[14] 42 U.S.C. § 1395ww(d)(3) (2009).
[15] Balanced Budget Act, Pub. L. No. 105-33, § 4410.
[16] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148 § 3141; 42 C.F.R. § 412.64(e); 75 Fed. Reg. 50,042, 50,413.
[17] *See Cape Cod v Sebelius*, 630 F.3d 203 (D.C. Cir. 2011).

## About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers and welfare benefit plans. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations, and address compliance matters. We also represent health care providers in reimbursement audits, appeals, litigation, and transactions. We help sponsors of welfare benefit plans understand and comply with federal and state laws and prepare plan documents. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.