DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
410-786-2671

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD

Order No. 4: Updating CMS Website URLs

I. Background

In September 2023, CMS redesigned its public-facing website CMS.gov, in order to organize, structure, and label content in an effective way to help people more efficiently find information and complete tasks. As part of this redesign, CMS has changed CMS.gov URLs (*i.e.*, uniform resource locators). Accordingly, the Board has made conforming changes to the Board Rules and those changes were limited to updating twelve (12) CMS.gov URL references.

II. Order

The Provider Reimbursement Review Board ("Board") hereby issues these Board Rules with the updated CMS.gov website URLs. This Order and attached Board Rules shall be published at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders and shall remain in effect until further order of the Board.

Provider Reimbursement Review Board Rules

Version 3.2

Effective December 15, 2023

Provider Reimbursement Review Board
CMS Office of Hearings
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https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board

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Rule 1 Overview

1.1 Authority

The Provider Reimbursement Review Board Rules will be referred to as "Rules." These Rules govern proceedings before the Provider Reimbursement Review Board ("PRRB" or "Board") and they are consistent with § 1878 of the Social Security Act (codified at 42 U.S.C. § 1395oo) and 42 C.F.R. §§ 405.1801 – 405.1889. The Board has discretion to take action as outlined in 42 C.F.R. § 405.1868 if a party fails to comply with these Rules or fails to comply with a Board Order or Instruction. While these Rules cite regulatory cross-references as a guide, the omission of a cross-reference does not excuse the parties from meeting all controlling statutory and regulatory requirements.

The Board will periodically issue Orders that are not case specific and apply generally to the Board's procedures and may modify or revise its Rules on a temporary basis. The Board considers the Orders as addenda to the Rules and will post these Orders with the Rules on the Board's website at: https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders. The Board previously issued similar temporary instructions as Board Alerts (*see, e.g.*, Board Alert 19).

1.2 Rules Apply to Individual and Group Appeals

Notwithstanding references to the term "provider" in the singular, all Rules apply to both individual and group appeals unless the Rule indicates otherwise (*e.g.*, group schedule of providers).

1.3 Good Faith Expectations

In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

1.4 Confidential Information

The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for protected health information ("PHI") or other personally identifiable information ("PII") to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board.

Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (*i.e*., untraceably remove) the names and numbers and replace them with non-identifying sequential numbers. If the confidential information itself is necessary to support your position, you must file a request seeking permission from the Board to submit unredacted PHI or PII with the Board, at least ***fourteen (14) days*** prior to the document deadline. If permission is granted, the Board will instruct how the PHI or PII should be submitted (*i.e*., in OH CDMS or in hard copy as necessary). A redacted version of the document should also be filed in OH CDMS. Any documentation submitted with unredacted PHI or PII (not submitted under seal) will be permanently removed from the record and will not be considered by the Board.

1.5 References to Days

The term “days” referenced in this document denotes calendar days unless otherwise specified.

1.6 Accessibility Standards

The Board is committed to making the appeals process accessible to people with disabilities. We strive to meet or exceed the requirements of § 508 of the Rehabilitation Act (codified at 29 U.S.C. § 794d), as amended in 1998.

If any Board correspondence or the electronic appeals system cannot be accessed due to a disability, please contact our Section 508 Team via email at 508Feedback@cms.hhs.gov. For more information on CMS Accessibility and Compliance with Section 508, see the CMS Accessibility & Nondiscrimination for Individuals with Disabilities Notice.

If you require accommodations at any time during the appeals process, including at a hearing, please contact your Board Advisor.

Rule 2 The Office of Hearings Case and Document Management System (“OH CDMS”)

2.1 Filings with the Board

2.1.1 Mandatory Electronic Filing

Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an **exemption** granted under Rule 2.1.2 applies. OH CDMS is a web-based portal for parties to electronically file and maintain their cases and to correspond with the Board. Access to the system is granted to registered users, as needed, based on their roles.

Access to specific cases is limited to the parties of each case, including party representatives.

Individuals registering for access to OH CDMS should allow for up to ***ten (10) days*** to complete registration as it is a multi-step process to obtain secure access to the web-based portal itself and to OH CDMS.

Refer to the webpage at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing to access links for the following:

1. *The CMS Salesforce Enterprise Integration (SEI) Portal*. —The CMS SEI portal is the website portal through which OH CDMS may be accessed.

2. *The OH CDMS External Registration Manual*. —This manual provides instructions on how to initially register as a user of OH CDMS through the CMS SEI Portal. Be aware that you must first register for access to the SEI portal before you can proceed with registering for access to OH CDMS.

3. *The OH CDMS PRRB User Manual*. —This manual, with its related supplements, provides instruction on how to properly file appeal-related documents within OH CDMS and manage your account. If there are any inconsistencies between the PRRB OH CDMS User Manual and the Board Rules, then the Board Rules control.

4. *OH CDMS Projected System Maintenance Dates*. —This lists the scheduled dates and time for maintenance for OH CDMS. If scheduled maintenance is set to occur on a weekday, it will be set after normal business hours.

The manuals and other documents on this webpage will be revised as necessary to reflect modifications and enhancements to OH CDMS. It is the user's responsibility to check regularly for updates, modifications, and changes to the OH CDMS PRRB User Manual (including the related supplements) and to be aware of when the system is down for scheduled maintenance. For any technical system issues, please contact the OH CDMS Help Desk at 1-833-783-8255 or email helpdesk_ohcdms@cms.hhs.gov.

2.1.2 Exemptions to Mandatory Electronic Filing

The Board recognizes that, in limited circumstances, it may be necessary for a party to request to file an appeal or other documents in an existing case(s), in ***hard copy***, outside of OH CDMS. A party who desires an exemption to the mandatory electronic filing requirement of Rule 2.1 must file a request as described below. An exemption may be granted for a specified period of time or on a permanent basis. If the Board grants a request, then the Board will explain the scope and duration of the exemption.

A. Disability under Rule 1.6.—If filing through the electronic appeals system cannot be completed or is materially hindered due to a disability (*see* Rule 1.6), the party should contact the Board at least ***ten (10) days*** prior to the filing deadline.

B. Extraordinary Circumstances. —A party may file in ***hard copy*** a request for an exemption due to extraordinary circumstances. *Except in cases of impossibility*, the request must be filed in hard copy and received by the Board at least ***ten (10) days*** prior to any filing deadline(s) impacted by the extraordinary circumstances. Please contact the Board at 410-786-2671 and PRRB@cms.hhs.gov for additional information if the request is time sensitive.

2.1.3 Extension for a Board-Set Deadline Due to Technical Difficulties with Electronic Filing

The Board has set deadlines to make certain filings in existing appeals including, but not limited to, deadlines for filing preliminary or final position papers, Schedules of Providers, witness lists, and case status reports (hereinafter "Board-Set Deadlines"). Note that Board-Set Deadlines do not include the deadlines for filing an initial appeal request (including a direct add to a group appeal) or adding issues to individual appeals or any other deadlines established by statute or regulation.

If a case representative experiences technical issues during filing within OH CDMS (including technical issues related to becoming a registered user), the case representative should seek assistance from the OH CDMS Help Desk to both document their issue and to resolve it prior to the Board-Set Deadline. To the extent the issue cannot be resolved by the Board-Set Deadline and the case representative makes a late filing, then the ***registered*** user should document their issues and submit their filing electronically ***within twenty-four (24) hours*** of the issue being resolved by the Help Desk. As part of this filing, the case representative must request an extension due to technical difficulties and provide satisfactory proof to establish good cause for the late filing. In this regard, the request should:

- Describe the technical issue;
- Describe when it was identified;
- Describe their efforts to resolve the issue;
- Identify the OH CDMS Help Desk ticket number opened to address the issue;
- Include a copy of the notice from the OH CDMS Help Desk confirming that the technical issue was resolved; and
- Confirm whether there are any other registered users in the case representative's organization and, if so, explain why the other user(s) could not make the filing.

If the Board finds good cause for the requested extension, then the Board will accept the filing as timely. Note that, for purposes of this Rule, an extension may not be based on administrative oversight, an ongoing discussion for administrative resolution, a change in case representative, or scheduled maintenance for OH CDMS.

2.1.4 Extension to Filing an Appeal Under 42 C.F.R. § 405.1836 (Including Direct Adds to a Group)

The Board has limited authority under 42 C.F.R. § 405.1836 to extend the deadline for filing an appeal (including a direct add to a group appeal). Specifically, this regulation states that "[t]he Board may find good cause to extend the time limit ***only if*** the provider demonstrates in writing it could not be expected to file timely ***due to extraordinary circumstances beyond its control*** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) . . . ." Accordingly, the case representative must file the request for extension electronically and provide any relevant information and documents "demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control." Note that the term "good cause" as used elsewhere in the Rules is not synonymous with how that term is used in 42 C.F.R. § 405.1836.

2.2 Correspondence through OH CDMS

2.2.1 Parties' Submissions to the Board

Pursuant to Rule 2.1.1, all submissions (*e.g.*, appeal requests, correspondence, position papers) must be filed electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies. The timing of data entry and document uploads to OH CDMS is captured in OH CDMS via a Confirmation of Correspondence which also serves as proof of delivery.

Note: If you file an appeal or other document using OH CDMS, ***do not file*** a duplicate hard copy with the Board unless the Rules require it or the Board specifically instructs you to do so.

2.2.2 Board Correspondence and Decision Issuances

The Board utilizes OH CDMS to issue its correspondence via email to the parties of an appeal. That includes all types of correspondence, such as the Acknowledgement Letter, Notice of Hearing, requests for additional information or briefings, jurisdictional and substantive decisions, etc. When issued, an email will be sent to all parties with the referenced correspondence included as an attachment. OH CDMS maintains a copy of the correspondence in the electronic record for the relevant appeal(s) for reference in accordance with CMS record retention policies.

Rule 3 Correspondence Requirements

3.1 Correspondence Requirements for Electronic Filings

Effective November 1, 2021, parties must submit documents and information electronically to the Board through OH CDMS unless an exemption granted under Rule 2.1.2 applies. Electronic

submissions through OH CDMS will be accepted as timely filed until **11:59 p.m. Eastern Time** on the filing due date.

It is the user's responsibility to be aware of system unavailability due to scheduled maintenance periods which are posted, in advance, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

3.2 Delivery of Hard Copy Filings Allowed Under Rule 2.1.2

If an exemption granted under Rule 2.1.2 applies to a particular submission, then the hard copy filing of that item must be submitted in one of the following ways:

- by regular mail through the United States Postal Service (USPS);
- by express or overnight mail by a nationally-recognized next-day courier (such as USPS' Express Mail, Federal Express, United Parcel Service, etc.); or
- by hand delivery or other courier ***but only if*****:** (1) at least 24 hours prior to a planned hand delivery, the party calls 410-786-2671 ***and*** sends an email to PRRB@cms.hhs.gov to request instruction on how, where, and when to make the filing by hand delivery; and (2) the party follows the instructions received from the Board for the hand delivery. Hand deliveries are extraordinary, and the Board requires this advance notice and coordination to ensure someone is available from the Board to receive the hand delivery.

Further, the following address must be used for any hard copy filing:

Provider Reimbursement Review Board
CMS Office of Hearings
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850

If a party files hard copy correspondence, it is responsible for maintaining evidence of timely filing. The normal business hours for the mail room are **8:00 a.m. to 4:00 p.m.**, Monday through Friday. CAUTION: The Board does ***not*** accept appeals or other correspondence submitted by email or fax.

3.3 Timely Delivery

Be sure to keep track of when filings are due (*see* Rule 4.4) and to allow sufficient time for documents to be received by the Board in a ***timely*** manner, on or before the filing deadline. *See also* Rule 4.5 addressing date of receipt.

3.4 Service on Opposing Parties

Copies of any document filed with the Board must simultaneously be sent to the opposing party **and** to the Appeals Support Contractor.

3.4.1 When Both Parties Are Registered for OH CDMS

OH CDMS will notify both parties and the Appeals Support Contractor of all submissions into the system. If both parties are registered for OH CDMS, then the system-generated notice confirming the correspondence will satisfy the requirement for service on the opposing party.

3.4.2 When One Party Receives an Exemption under Rule 2.1.2

If a party receives an exemption under Rule 2.1.2 and elects to submit its appeal and other documentation in hard copy to the Board pursuant to that exemption, then that party must:

- include a notice with each filing that the information is being filed outside of OH CDMS; and
- timely submit a complete copy of the filing ***directly*** to both the opposing party *and* to the Appeals Support Contractor.

The party that is registered for OH CDMS may submit its filings through OH CDMS for purposes of fulfilling Board filing requirements, but still bears the responsibility to timely serve the opposing party.

3.5 Caption and Case Number on All Submissions

All filings and correspondence must contain the following information in the caption for the filing:

- The case number (except for the initial hearing request);
- The name of –
  - The provider and the provider number for individual appeals or
  - The group name for group appeals; and
- The fiscal period being appealed.

3.6 Submission of Materials Involving Multiple Case Numbers

If a submission applies to multiple cases, the submission must caption all impacted cases. The Board also requires that the requisite documentation be provided for each case referenced in the document. If the filing pertains to multiple cases and there is insufficient room to list all of the information required under Rule 3.5 in the caption, then include the information in an Appendix.

3.6.1 Electronic Submissions through OH CDMS

Transfer requests and submissions related to consolidated Notices of Hearings involve multiple cases but only need to be filed once in in OH CDMS. Specifically:

- Transfers need only be submitted in the originating individual case. OH CDMS will automatically populate the receiving group case with the corresponding information.
- Position papers and other filings specifically requested in a consolidated Notice of Hearing need only be filed in the lead case. The notice must be identified as

"consolidated" and have an attached list of related cases. OH CDMS will populate all of the cases on the related case listing with the documentation filed in response to the Notice of Hearing. NOTE--This applies only to *consolidated* cases and does not apply to cases that are merely being concurrently scheduled for the same hearing date.

3.6.2 Hard Copy Submissions Where Multiple Case Numbers Are Captioned Within a Single Document

If an exemption granted under Rule 2.1.2 applies to a particular submission and the submission covers multiple case numbers, the Board requires that enough copies be sent for **each case** referenced in the document and the respective case number must be highlighted on each copy. If the submission applies to a consolidated hearing (*e.g*., a consolidated final position paper or witness list), parties may check with the Board Advisor to determine if the requirement to file multiple copies may be waived on a case-by-case basis.

Rule 4 Board Jurisdiction and Issues Under Appeal

4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements. A jurisdictional challenge (*see* Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

4.2 Parties to the Appeal

Only a provider or group of providers is entitled to file an appeal to the Board. A home office is not a provider and cannot file an appeal. (Allocations made to a provider from the home office cost statement can be appealed by a provider only from an adjustment made to the provider's claimed home office costs on the provider's Medicare cost report.)

4.3 Commencement of Appeal Period

4.3.1 Contractor/CMS/Secretary Final Determination

Final determinations include:

- Notices of Program Reimbursement;
- Revised Notices of Program Reimbursement;
- Exception Determinations;

- Quality Reporting Program Payment Reduction Determinations; and
- Other determinations issued by CMS or its contractors with regard to the amount of total reimbursement due the provider.

The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).

The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

4.3.2 Federal Register Notice

The date of receipt of a Federal Register Notice is the date the Federal Register is published. The appeal period begins on the date of publication and ends 180 days from that date.

4.3.3 Lack of Timely Contractor Determination

As provided at 42 C.F.R. § 405.1835(c), a provider may appeal if a final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in 42 C.F.R. § 413.24(f)). The date of receipt by the Medicare contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped “Received” on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

The appeal period begins at the expiration of the 12-month period for issuance of the final contractor determination and ends 180 days from that date. There is no additional 5-day presumption allowed. *See* 42 C.F.R. § 405.1835(c).

4.4 Due Dates

4.4.1 Due Dates for New Appeals

New appeals must be received by the Board no later than 180 days from the commencement of the appeal period as specified in Rule 4.3. *See* Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 “due to extraordinary circumstance beyond [the party’s] control.”

4.4.2 Due Dates for Other Filings

All filings other than an appeal request or request to add issues (*e.g.*, position papers and other responsive documents) must be received by the Board no later than the date specified on the Board’s notice or, if silent, the date specified in these Rules. If a party fails to file by

the established due date, the Board may take action as described in 42 C.F.R. § 405.1868. For example, Rule 23.4 addresses the timely filing of preliminary position papers and specifies that the Board will dismiss the appeal if the representative for the provider(s) fails to file their preliminary position paper or PJSO by the established due date.

4.4.3 Due Date Exceptions

If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (*e.g*., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R. § 405.1801(d)(3).

4.5 Date of Receipt by the Board

The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:

A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; or

B. If the filing is permitted pursuant to an exemption under Rule 2.1.2, the date of receipt is:

- The date of delivery to the Board as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next-day courier. It is the responsibility of the provider to maintain a record of the delivery. *See* 42 C.F.R. § 405.1801(a)(2)(i).

- The date stamped "received" by the Board on documents submitted by regular mail, hand delivery, or couriers not recognized as a national next-day courier. This provision also applies if the party is unable to supply the next-day courier's tracking bill as noted above. *See* 42 C.F.R. § 405.1801(a)(2)(ii).

4.6 No Duplicate Filings

4.6.1 Same Issue from One Determination

A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).

4.6.2 Same Issue from Multiple Determinations

Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR covering the same time period in separate appeals. *See* Rule 6.3 for instruction on how to add a new determination to a pending individual appeal covering the same time period.

4.6.3 Issue Previously Dismissed or Withdrawn

Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case. For example, if the provider has an issue dismissed from its individual appeal, it may not appeal or pursue that same issue in a group appeal covering the same time period. Refer to Rule 47 for motions for reinstatement.

4.7 Issue Location

4.7.1 General Rule

The Board will treat an issue as being included in the case in which it was requested. However, if the Board subsequently determines that the inclusion is improper, it will dismiss or transfer the issue as appropriate.

4.7.2 Exceptions – Board Order Must Establish Location

4.7.2.1 Requests to Join a Fully Formed Group

The Board has discretion to grant or deny a request to join a fully formed group. (*See* 42 C.F.R. § 405.1837(e)(4) and Rule 19.5.)

4.7.2.2 Transfer Requests from Group Cases into Other Appeals

Once a provider has joined a group appeal, a transfer from the group appeal will be permitted only upon Board approval of a provider's written motion. (*See* Rules 17 and 18.)

4.7.3 When to Transfer Issues to Groups (Optional or CIRP)

The Board expects that transfers of issues from individual appeals to group appeals will be effectuated ***prior to*** submission of the preliminary position paper for the individual appeal. (*See* Rule 12.11.)

Rule 5 Provider Case Representative

5.1 Persons

A party may be represented by legal counsel or by any other person appointed to act as its case representative at any proceedings before the Board. All actions taken by the case representative are considered to be those of the provider and notice of any action or decision sent to the case representative has the same effect as if it had been sent to the provider itself.

The case representative is the individual with whom the Board maintains contact. The case representative may be an external party (*e.g.*, attorney or consultant) or an internal party (*e.g.*,

employee or officer of the provider or its parent organization), but there may be ***only*** one case representative per appeal (*see* Rule 4.6 prohibiting duplicate appeals). The Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization.

5.2 Responsibilities

The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:

- The Board's governing statute at 42 U.S.C. § 1395oo;
- The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
- These Rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (*see* Rule 1.1).

Further, the case representative is responsible for:

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- Responding timely to correspondence or requests from the Board or the opposing party.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

5.3 Communications with Providers

The Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (*see* Rule 5.2). The Board will address notices only to the official case representative. Accordingly, the Board recommends that case representatives regularly check their email (including any filtered email) to ensure they do not miss important information related to their pending case(s) (*e.g.*, notice of Board deadlines, Board rulings or decisions, or documents filed by other parties).

If other members of the case representative's organization contact the Board, the Board will assume the contact is authorized by the case representative and may communicate with those individuals about an appeal. In teleconferences with the Board or in hearings, the case representative may be assisted by others outside of his/her organization.

5.4 Representation Letter

A representation letter is required whether designating an external or internal case representative. If the provider is ***not*** commonly owned or controlled when the representation

letter is being executed, then the letter designating the case representative must be on the provider's letterhead and be signed by an authorizing official of the provider organization. If the provider ***is*** commonly owned or controlled when the representation letter is being executed, then the letter designating the case representative must be on letterhead that identifies the parent corporation (whether it's the provider's letterhead or the parent corporation's letterhead) and must be signed by an authorizing official of the provider or parent organization.

In addition, the representation letter must reflect the provider's name, number, and fiscal year under appeal. The letter must ***not*** be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised. Finally, the representation letter must contain the following contact information regarding the case representative:

- name,
- organization,
- address,
- telephone number, and
- email address.

If the provider wishes to change its case representative, it must submit an updated letter to the Board and a copy to the Medicare contractor and Appeals Support Contractor (*see* Rule 3.4 about service through OH CDMS). The provider must also notify both the old case representative and the new case representative of the change.

5.5 Withdrawal of Representation

A case representative may withdraw his or her appearance by filing a notice of withdrawal with the Board.

5.5.1 Deadlines Must Continue To Be Met

Withdrawal of a case representative, or the recent appointment of a new case representative, generally will not be considered cause for delay of any deadlines or proceedings.

5.5.2 Provider's Consent Obtained for Withdrawal

A notice of withdrawal must be signed by the case representative and an authorized official of the provider. Such notice should also contain a statement regarding the replacement case representative in accordance with Rule 5.4.

5.5.3 Provider's Consent Not Obtained for Withdrawal

If a provider's written consent is not obtained, the case representative must file a withdrawal notice listing the provider's last known contact information (name, address, telephone number, and email address). The case representative must also document that the withdrawal notice was sent to the provider at the last known point of contact.

Rule 6 Filing an Individual Appeal

6.1 Initial Filing

6.1.1 Request and Supporting Documentation

To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.

6.1.2 Deadlines and Timeframes Relating to Initial Filing

The Board will issue an Acknowledgement and Critical Due Dates Notice establishing filing deadlines for preliminary position papers and other documentation as necessary. (*See* Rule 9).

6.2 Adding a New Issue to an Individual Case

6.2.1 Request and Supporting Documentation

Subject to the provisions of 42 C.F.R. § 405.1835(e), an issue may be added to an individual appeal if the provider:

- timely files a request with the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 day period for filing the initial hearing request, and
- the request meets the minimum filing requirements as identified in 42 C.F.R. § 405.1835(e).

Reference Rules 7 and 8 as well as Model Form C – Request to Add Issue (Appendix C) for guidance on all required OH CDMS data fields and supporting documentation.

6.2.2 Deadlines and Timeframes Relating to Added Issue

All deadlines and timeframes set by the Board in response to the filing of the initial appeal will also apply to the added issue, unless the Board instructs otherwise.

6.3 Adding a New Determination to an Individual Case

6.3.1 Request and Supporting Documentation

For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed

(*e.g.*, NPR, revised NPRs, exception request denials, etc.), providers must timely request to add the subsequent determination to its pending appeal for that cost reporting period. Reference Rules 7 and 8 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation.

The Board, upon its own motion or motion of the parties, may issue separate case numbers for the new determination(s) for administrative efficiency.

6.3.2 Deadlines and Timeframes Relating to Added Determination

The Board will issue an Acknowledgement and Critical Due Dates Notice for the additional final determination. This notice will establish new due dates for supplemental position papers related to the new determination(s) and its associated issue(s).

6.4 Amount in Controversy

An individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing. *See* 42 C.F.R. §§ 405.1835 and 405.1839. A calculation of the amount in controversy with supporting documentation must be provided for ***each*** issue.

6.5 Certifications for Individual Appeals

The person filing the appeal request on behalf of a provider must provide the following certifications on behalf of the provider and/or chain organization, as applicable:

- I certify that none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.
- I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).
- I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.
- I am authorized to submit an appeal on behalf of the listed provider.

6.6 Information on Parent Owner or Organization

Pursuant to 42 C.F.R. §§ 405.1835(b)(4) and 405.1835(d)(4), if a provider is under common ownership or control, the appeal request must include the name and address of the parent corporation ***for the year under appeal***.

COMMENTARY:

The collection of information on the parent corporation in Board Rule 6.6 as well as Board Rule 5.4 is consistent with 42 C.F.R. §§ 405.1835(b)(4) and 405.1835(d)(4) and facilitates provider compliance with the mandatory group requirements for common issues, as delineated at 42 C.F.R. § 405.1837(b) and Rules 12.3.1, 12.11, 13, and 19.2.

Rule 7 Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction

The provider must support the determination being appealed and the basis for its dissatisfaction for ***each*** issue under appeal consistent with 42 C.F.R. § 405.1835(b) or (d) as applicable. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

7.1 Final Determination

7.1.1 General Requirements

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination.

> Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18).

Include a copy of the **final** determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting payment reduction decision. Note that preliminary determinations are not appealable. (*See* Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

7.1.2 Additional Requirements for Specific Determination Types

7.1.2.1 Revised NPR

Attach the reopening request that preceded the revised NPR (if applicable) ***and*** the reopening notice issued by the Medicare contractor. Also identify the issuance dates of the original NPR and all prior revised NPRs.

7.1.2.2 Exception Request

Identify the type of exception. Also identify the basis to file an appeal before the Board if the appeal rights are not specified in the exception decision.

7.1.2.3 Federal Register Notice

Identify the Federal Register citation and provide the applicable pages of the Federal Register.

7.1.2.4 Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the final reconsideration decision on which the appeal is based.

7.1.2.5 Other Final Determination

For any other final determination not listed above, identify the specific final determination being appealed and the authority granting the Board's jurisdiction over the dispute.

7.2 Issue-Related Information

7.2.1 General Information

The following information and supporting documentation must be submitted for each issue raised in the appeal request.

- An issue title and a concise issue statement describing:
  - the relevant adjustment(s), including the adjustment number(s),
  - the controlling authority (*e.g.*, specific regulation, Federal Register issuance, manual provision, or Ruling),
  - why the adjustment(s) is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the Board.
- A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.

- A calculation or other support for the reimbursement effect noted in the issue statement.
- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2 Additional Information

Rule 7.2.1 is not an exhaustive list and providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s) as relevant.

Example: Revised NPR workpapers and applicable cost report worksheets to document that the issue under appeal was specifically adjusted.

7.3 Self-Disallowed Items

7.3.1 For Cost Reporting Periods Beginning Before 01/01/2016

7.3.1.1 Authority Requires Disallowance

If the provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:

- A concise statement describing the self-disallowed item;
- The reimbursement or payment sought for the item, including the calculation of the reimbursement sought with supporting documentation; and
- The authority that predetermined that the claim would be disallowed.

7.3.1.2 No Access to Data

If the provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

7.3.2 Protest for Cost Reporting Periods Ending On or After 12/31/2008 but Beginning Before 01/01/2016

The final rule published on May 23, 2008 specifies that, effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in the Provider Reimbursement Manual, CMS Pub. 15-2, § 115. *See* 73 Fed. Reg. 30190, 30195 (May 23, 2008); 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

For the appeal, you must include the following for ***each*** protested item being appealed:

- Identify the amount that was protested for each specific item being appealed;
- Attach a copy of the protested items worksheet that was submitted with your as-filed cost report for each of the items protested; and
- Include the as-filed Worksheet E or audit adjustment report to demonstrate the total protested claim.

See Provider Reimbursement Manual, CMS Pub. No. 15-2, § 115. Note: CMS Ruling 1727-R governs cost reporting periods ending on or after December 31, 2008 and beginning before January 1, 2016.

7.3.3 Protest for Cost Reporting Periods Beginning On or After 01/01/2016

42 C.F.R. § 405.1873(a) specifies that, "[i]n order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in [42 C.F.R.] § 413.24(j))." In particular, 42 C.F.R. § 413.24(j)(2) specifies the procedures the provider must follow to self-disallow a specific item. *See also* 42 C.F.R. § 413.24(j) generally; 80 Fed. Reg. at 70555-70557 (Nov. 13, 2015); Provider Reimbursement Manual, CMS Pub. 15-2, § 115.

For the appeal, you must provide the following for ***each*** protested item being appealed:

- Identify the amount in the protested amount line (or lines) of the provider's accepted cost report that was protested for the specific item being appealed;
- Attach a copy of the protested items worksheet that was included in the accepted cost report under appeal in compliance with 42 C.F.R. § 413.24(j)(2)(ii) in order to explain why the provider self-disallowed each item and describe how reimbursement was calculated for each self-disallowed item; and
- Attach either the as-filed Worksheet E from the accepted cost report or the associated audit adjustment report to demonstrate the total protested amount that was claimed for the specific item being appealed.

7.4 Determination of Appropriate Cost Report Claim (Applies to Cost Reporting Periods Beginning On or After 01/01/16)

Effective for cost reporting periods beginning on or after January 1, 2016, 42 C.F.R. § 413.24(j) (as referenced in 42 C.F.R. § 405.1873(a)) includes a "[s]ubstantive reimbursement requirement of an appropriate cost report claim." Specifically, § 413.24(j)(1) states that, "[i]n order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, *the provider's cost report*, whether determined on an as submitted, as amended, or as adjusted basis . . ., must include an appropriate claim for the specific item . . . ." (Emphasis added.) If any party questions whether *the provider's cost report at issue* in an appeal before the Board complies with the regulatory requirement (*i.e.*, questions whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed), then that party must follow the process in Rule 44.5-44.6 to initiate Board review of such question(s).

7.5 Failure to Timely Issue Final Determination

If the appeal is based on the failure of the Medicare contractor to timely issue a final determination, provide:

- evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
- evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal.

The Medicare contractor must notify the Board if a cost report filing raised under this Rule was rejected or if a subsequent cost report filing was made that would supersede the cost report under appeal.

Rule 8 Framing Issues for Adjustments Involving Multiple Components

Some issues may have multiple components. To comply with the requirements of 42 C.F.R. § 405.1835, appeal requests must specifically identify the items in dispute, and each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. Several examples are identified below, but these examples are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include, but are not limited to:

- Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days (*see, e.g.,* CMS Ruling 1498-R at 7-8);
- Dual eligible Medicare Part C/Medicaid, which is often referred to as DSH Medicare Advantage Days (*see*, *e.g.*, CMS Ruling 1739-R);
- Pre-1999 dual eligible Medicare HMO days;
- SSI data matching (*see, e.g.*, CMS Ruling 1498-R at 4-6);
- SSI eligible days (*see, e.g.*, *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D12 (Mar. 28, 2017));
- State/program specific general assistance days;
- Section 1115 waiver days (program/waiver specific);
- Medicaid adolescent/child days in a psychiatric residential treatment center; and
- Observation bed days.

B. Bad Debts

Common examples include, but are not limited to:

- Crossover bad debts;
- Collection effort;
- Use of collection agency;
- 120-day presumption; and
- Indigence determination.

C. Graduate Medical Education/Indirect Medical Education

Common examples include, but are not limited to:

- Managed care days;
- New programs;
- *Current* year resident count;
- *Prior year* resident count;
- *Penultimate year* resident count;
- Intern to bed ratio;
- Rotations to non-hospital settings; and
- Direct graduate medical education weighted cap on full-time equivalent (FTE) residents.

D. Wage Index

Common examples include, but are not limited to:

- Wage data corrections;
- Occupational mix;
- Wage vs. wage-related costs;
- Pension;
- Rural floor; and
- Data corrections.

Rule 9 Board Acknowledgement of Appeals

The Board will send an acknowledgement notice via email to the designated representative confirming receipt of the appeal request and identifying the case number assigned. Such an acknowledgement notice does not limit the Board's authority to require more information or to dismiss the appeal if it is later found to be jurisdictionally deficient. If the appeal request does

not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action.

The acknowledgement and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines (including deadlines established by a proposed joint scheduling order ("PJSO") per Rule 23.2) may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

> **COMMENTARY:**
>
> If the case representative has not received an acknowledgement letter from the Board establishing critical due dates ***within thirty (30) days*** following the filing of an appeal request, the representative should contact the Board at 410-786-2671 or PRRB@cms.hhs.gov to the extent the new case is not appearing in the representative's list of open/pending cases in OH CDMS.

Rule 10 Medicare Contractor Response upon Filing of Individual Appeal

10.1 Duty to Confer

Once the deadline for the provider to add issues has passed (*see* Rule 6.2), it is the Medicare contractor's responsibility to perform the following actions as provided in 42 C.F.R. § 405.1853 and Board Rules:

- Promptly review the provider's appeal and the information underlying the determination at issue, after it is filed;
- Advise the Board, in writing, as to any challenges to Board jurisdiction under Rule 44.4, including identification of the issue(s) challenged, the basis for the challenge and any supporting documentation;
- Advise the Board, in writing, as to any Substantive Claim Challenges which must be filed consistent with the instruction in Rule 44.5;
- Ensure that the record before the Board includes the evidence the Medicare contractor considered in making the determination at issue, or, where applicable, the evidence that CMS or the Secretary considered in making the determination at issue; and
- Confer with the provider regarding stipulations (*see* Rule 35.2).

10.2 Duty to Respond to Requests

If the Medicare contractor opposes a provider's expedited judicial review request, motion for good cause extension of time for requesting a Board hearing, mediation request, or any other request, its response must be timely filed in accordance with Rules 42, 43, and 44.

Rule 11 Intentionally Left Blank

Rule 12 Filing a Group Appeal

12.1 Initial Filing

To file a group appeal, the Group Representative must log onto OH CDMS and follow the prompts. Refer to Rule 16 and Model Form B – Group Appeal Request (Appendix B) for guidance on all required OH CDMS data fields and supporting documentation. Providers may be added to the group appeal via transfer or direct add.

COMMENTARY FOR GROUP APPEALS FILED THROUGH OH CDMS:

Within OH CDMS, the direct addition of providers to a group appeal may occur as part of the group appeal request. However, transfers of providers to a group case must be initiated from the originating individual case and transfer requests require the identification of the group case number. Therefore, a group must be established ***before*** transfers may be effectuated.

Accordingly, if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the providers must be transferred ***immediately*** following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.

12.2 General Requirements

In accordance with 42 C.F.R. § 405.1837, a group must meet the following requirements:

- Each participating provider (whether added by transfer or direct add) must individually satisfy the requirements for a Board hearing under 42 C.F.R. § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement.
- The matter at issue in the group appeal must involve a ***single*** question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group.
- The amount in controversy must be $50,000 or more in the aggregate.

12.3 Types of Groups

12.3.1 Mandatory Common Issue Related Party ("CIRP') Group

Providers under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. *See* 42 C.F.R. § 405.1837(b).

12.3.2 Optional Group

Providers **not** under common ownership or control may choose to join together to file an optional group appeal for a specific matter that is common to the providers for any fiscal year that ends in the same calendar year, but they are not required to do so.

12.4 Amount in Controversy Timeframe

The $50,000 threshold need not be met at group creation but must be met by the full formation of the group. (*See* Rule 19.)

12.5 Group Cost Reporting Periods

A group may cover only one calendar year unless the Board allows the group to be expanded. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of providers or the $50,000 amount in controversy requirements. The request must:

- Identify the additional calendar year(s) desired to be included in the group;
- Explain why the expansion is needed (*e.g*., to meet the minimum number of providers and/or to meet the $50,000 amount in controversy requirement); and
- Address whether there are any issues of fact or changes in legal authority that might result in different decisions across the years covered by the request in order to ensure that, if the Board were to grant the requested expansion, the resulting expanded group would continue to meet the requirements for a group appeal (*see* Rule 13).

Failure to include the above information in the request will result in denial of the request.

12.6 Number of Providers in Group

This Rule is based on 42 C.F.R. § 405.1837(b)(3).

12.6.1 Mandatory CIRP Groups

A CIRP group may be initiated by a single provider under common ownership or control, but at least two different providers must be in the group upon full formation. (*See* Rule 19.)

12.6.2 Optional Groups

Optional group appeals must have a minimum of two different providers, both at inception and at full formation of the group. The Board may limit the number of providers in an optional group appeal, or divide existing optional groups into various case numbers, as it deems necessary to ensure efficient case management. The Board may request the parties' input prior to limiting or dividing a case.

12.7 Optional and Mandatory Group Providers Not Combined

Providers that are not part of a CIRP organization for the calendar year at issue may not join a CIRP appeal covering that year. Similarly, providers that are part of CIRP organizations for the year at issue may not join an optional group covering that year unless the $50,000 aggregate amount in controversy requirement cannot be met by the CIRP providers or there are not at least two providers in the CIRP organization that have the issue for the year at issue. However, for judicial economy, separate groups involving the same issue may be heard concurrently.

12.8 Authorization for Group Representative

The Board will only recognize a single group representative for all participating providers in a group. Each provider must file a representation letter in accordance with Rule 5. Providers without a proper representation letter will not be permitted to join the group. It is the responsibility of the group representative to ensure that the participants in the group and, for CIRP group appeals, the appropriate official(s) at the home office or corporate headquarters, are kept regularly apprised of the group appeal.

12.9 Initial Selection of Lead Medicare Contractor

The group representative must designate a lead Medicare contractor based on the contractor that services the majority of providers listed on the initial appeal request, unless the group representative states he/she has a good faith belief that upon group completion (Rule 19.3), a different Medicare contractor will ultimately service the greatest number of providers.

12.10 Certifications for Group Appeals

The person filing the appeal request on behalf of a group must certify the submission, specifically:

- I certify that the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.
- I certify to the best of my knowledge that there are no other providers to which these participating providers are related by common ownership or control that have a pending request for a Board hearing on the same issue for a cost reporting period that ends in the same calendar year covered in this request. *See* 42 C.F.R. § 405.1837(b)(1)(i). (This certification applies to optional groups only.)

- I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.
- I am authorized to submit an appeal on behalf of the listed providers.

12.11 Timeliness of Transferring Issues to a Group Appeal

Providers transferring issues from an individual appeal to a group appeal must do so as soon as possible, generally prior to filing the individual appeal's preliminary position paper.

For those providers under common ownership or control, the transfer should take place upon identification of another provider that triggers the mandatory group requirement, but no later than the filing of the preliminary position paper. The Board may direct the formation of mandatory groups to comply with the regulatory requirements. Failure by a party to comply with such requests and associated deadlines may result in the Board taking action pursuant to 42 C.F.R. § 405.1868.

Rule 13 Common Group Issue

The matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation, or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific provider may be presented as representative of all group members.

13.1 Multiple Issues in Group Appeal

Upon notification from the Board that a group appeal involves more than a single common question of fact or interpretation of law, regulation or CMS policy or Ruling, the group representative must take one of the following actions within 90 days, unless the Board specifies an alternate deadline in its notice:

a. File a request to withdraw any excess issue(s) so that only one issue remains in the group;

b. File a request to bifurcate the group appeal that describes the issues that the provider is requesting be bifurcated; or

c. If the group representative disagrees with the Board's notice, file a brief with legal argument and any relevant supporting documentation explaining why the Board should find that the group contains a single issue.

Failure of the group representative to timely submit one of the above filings may result in the Board taking action per 42 C.F.R. § 405.1868.

Rule 14 Acknowledgement of Group Appeal

The Board will send an Acknowledgement and Critical Due Dates Notice via email to the group representative and the lead Medicare contractor confirming receipt of the group appeal and the case number assigned. Such an acknowledgement notice does not limit the Board's authority to require more information or to dismiss the appeal if it is later found to be jurisdictionally deficient. If the provider's appeal does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action.

The acknowledgement (or future correspondence) may also set various deadlines and due dates including, but not limited to, position paper deadlines, full formation of the group, discovery and other documentation requirements. Failure by a party to comply with such deadlines may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

Rule 15 Medicare Contractor's Responsibilities upon Receipt of Group Appeal

15.1 Challenging Lead Medicare Contractor Designation on Initial Filing

Within 10 days of receipt of the Board's Acknowledgement of the group, the Medicare contractor may challenge its designation as the lead Medicare contractor pursuant to Rule 19.4 criteria.

15.2 Advise Board if Group Is Proper

Within 30 days of receipt of the Board's acknowledgement of the group, the designated Lead Medicare contractor (*see* Rule 12.9) must advise the Board, in writing, of its position as to the following:

- whether the group appeal establishes a single common issue, and
- whether the parties creating the group meet the jurisdictional and appeal filing requirements (except that the amount in controversy need not be met until full formation of the group).

Rule 16 Requests to Join a Group Appeal

A provider may request to join an existing group by transferring the relevant issue from the provider's individual appeal to that group OR by directly appealing from a final determination. To

join a group appeal, file the transfer request or direct add request using OH CDMS, unless an exemption granted under Rule 2.1.2 applies to the particular submission. Refer to Rule 16.2 as well as Model Form D – Request to Transfer Issue (Appendix D) and Model Form E – Request to Directly Add Provider to Group (Appendix E) for guidance on all required OH CDMS data fields and supporting documentation.

16.1 Filing Requirements for Requests to Transfer from Individual Appeal

16.1.1 Transfer Requests via OH CDMS

Transfers made through OH CDMS must be initiated within the individual case and must:

- Identify the specific issue;
- Identify the group case number and confirm the group name of the case to which the issue is to be transferred; and
- Upload a copy of the representative letter associated with the group appeal.

16.1.2 Transfer Requests via Hard Copy

If an exemption granted under Rule 2.1.2 permits the transfer request to be submitted in *hard copy*, the provider is required to include the information noted in Rule 16.1.1 and attach the following supporting documents to its hard copy transfer request:

- **Two** copies of Model Form D – Request to Transfer Issue (Appendix D);
- A copy of the relevant final determination and associated supporting documentation identified in Rule 7;
- A copy of the relevant issue-related information identified in Rule 7;
- Documentation demonstrating that the issue was raised in the individual appeal, either through the initial appeal request or timely added to appeal subsequent to the initial request; and
- Affirmation that the issue being transferred is currently part of the individual appeal from which it is to be transferred (not previously withdrawn, transferred, resolved, or dismissed).

16.2 Filing Requirements for Requests to Join a Group Directly from a Final Determination

A direct add request must include the same information required for a provider filing an individual appeal (*see* Rules 6 through 8), including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal. This information must be provided in order for the Board to confirm that the direct add request meets the requirements for a Board hearing. *See* 42 C.F.R. §§ 405.1835(a), 405.1835(c), 405.1840(a).

16.2.1 Direct Add Requests via OH CDMS

Direct add requests submitted through OH CDMS may be initiated in conjunction with a new group appeal request or within an existing group.

16.2.2 Direct Add Requests via Hard Copy

If an exemption granted under Rule 2.1.2 permits the direct add request to be submitted in *hard copy*, then it must include all of the information identified in Rule 16.2 plus a copy of Model Form E – Request to Directly Add Provider to Group (Appendix E).

Rule 17 Transfers from Group Appeal into Other Appeals

The Board will not grant a request to transfer from a group case to another case (group or individual) except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation, common issue requirements, or CIRP group requirements. (*See* 42 C.F.R. § 405.1837.) No transfer from a group to another case is effective unless the transfer request is formally approved by the Board.

Rule 18 Restructuring of Groups

After providing notice to the parties and an opportunity to comment, the Board may require a group to restructure appeals either for judicial economy or to comply with the law, regulations, or these Rules.

Rule 19 Full Formation of Groups

Refer to 42 C.F.R. § 405.1837(e) for group appeal procedures pending full formation of the group and issuance of a Board decision.

19.1 Optional Groups

Within the Board's Acknowledgement for *optional* group appeals, the Board will set the deadline for the group to be fully formed (*i.e.*, complete), generally 12 months from the date of the group hearing request. The Board has the discretion to set a different deadline for case management or administrative efficiency purposes.

The Board deems a group fully formed upon the earlier of:

- The filing of a notice from the group representative that the group is fully formed;
- The deadline set by the Board;

- A Board Order that the group is fully formed; or
- The filing of a request for expedited judicial review ("EJR") by the group representative if: (1) the group representative has not previously certified that the optional group is fully formed; and (2) the EJR request does not include the representation that the optional group is fully formed. In this situation, the Board deems the optional group to be fully formed.

19.2 Mandatory CIRP Groups

Mandatory CIRP group appeals must include ***all*** providers eligible to join the group that intend to appeal the disputed common issue for the year(s) covered by the CIRP group. Within the Board's Acknowledgement of a CIRP group appeal, the providers are notified that, at the one-year mark (if they had not previously done so), they must notify the Board if the group is complete and, if not, which providers have not yet received a final determination for the specified fiscal year and intend to join the group. Note: If a representative is uncertain whether the CIRP group requirements apply to a provider(s), then the representative may file a request for a ruling from the Board and that request must include relevant information such as the provider acquisition date.

The Board deems a CIRP group appeal fully formed (*i.e.*, complete) upon the earlier of:

- The filing of a notice from the group representative that the group is fully formed;
- An Order by the Board finding that the group is fully formed where the Order is issued after the group representative has had the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group; or
- The filing of a request for expedited judicial review ("EJR") by the group representative if: (1) the group representative has not previously certified that the CIRP group is fully formed; and (2) the EJR does not include the representation that the CIRP group is fully formed. In this situation, the Board deems the CIRP group fully formed.

As stated in 42 C.F.R. § 405.1837(e)(1), "[w]hen the Board has determined that a [CIRP group] is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."

19.3 Change of Lead Medicare Contractor upon Full Formation

19.3.1 On Motion of Group Representative

If the group representative believes that the lead Medicare contractor should be changed, the group representative must contact the current and proposed lead Medicare contractors and file a Motion to change the designation of the lead Medicare contractor based upon the criteria in Rule 19.4 within 15 days of the full formation of the group. The group representative must indicate whether the Medicare contractors concur with the suggested change and send a copy of such Motion to both Medicare contractors. If the parties cannot

reach agreement, the Medicare contractors may file an objection setting out their reasons and the Board will determine the lead Medicare contractor.

19.3.2 On Motion of Lead Medicare Contractor

The current lead Medicare contractor may file a motion to challenge its designation as lead Medicare contractor (copying the group representative and proposed lead Medicare contractor) within 15 days of receipt of the schedule of providers and supporting documentation. The motion should indicate whether the proposed lead Medicare contractor and the group representative concur with such request.

19.4 Criteria for Selection of Lead Medicare Contractor

The Board considers the following factors when selecting the lead Medicare contractor:

- The Medicare contractor that services the greatest number of providers in the group, or
- If various Medicare contractors service the same number of providers, the amount in controversy for the providers serviced by each Medicare contractor.

19.5 Joining a Group Post Full Formation

The Board has discretion to grant or deny a request to join a fully formed group (CIRP or optional).

Rule 20 Group Schedule of Providers and Supporting Documentation – Procedure

If ***all*** the participants in a fully formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.

Prior to *certifying that the group is fully formed or the date on which a group is fully formed*, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS. If *all* of the participants in a fully formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully populated* in OH CDMS with the relevant supporting jurisdictional documentation (*i.e*., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).

20.1 Filing Requirements for Group Cases that Are Not Fully Populated in OH CDMS

20.1.1 Mandatory Electronic Filing

If any participants in a fully formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.,* Model Form G at Appendix G), for *all* participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise**. Specifically, *within sixty* (*60) days of the full formation of the group* (*see* Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21). The parties must submit this schedule and supporting documents electronically to the Board through OH CDMS unless an exemption granted under Rule 2.1.2 applies.

20.1.2 Additional Hard Copy Filing Required in Certain Situations

If Expedited Judicial Review is requested (*see* Rule 42) in a fully formed group case in which any participants are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must also prepare and submit in ***hard copy*** a traditional schedule of providers (*i.e.* Model Form G at Appendix G) for *all* participants in the group, in advance of, or concurrent with, the request for EJR. This hard copy submission must be bound, tabbed, and numbered, and it is *in addition to* the schedule of providers and jurisdictional documentation submitted electronically through OH CDMS in accordance with Rule 20.1.1.

Additionally, the Board reserves the right to request, with adequate notice to the parties, a ***hard copy*** of the schedule of providers and jurisdictional documentation, in addition to the schedule and supporting documentation submitted in OH CDMS, in cases the Board deems it necessary to facilitate resolution of the appeal (*e.g.,* prior to a hearing or to facilitate jurisdictional review).

Any schedule of providers and supporting documentation submitted in ***hard copy*** must contain the identical information submitted electronically through OH CDMS.

20.1.3 Medicare Contractor to Initially Review Format

If the schedule and supporting documentation is not submitted in the proper format as described below, the Medicare contractor is to notify the Board and group representative of the formatting deficiencies within 15 days of receipt (*see* Rule 20.3 below).

COMMENTARY:

The schedule of providers is designed to assemble various elements of documentation to demonstrate that the Board has jurisdiction over each provider to be included in the group. Because some groups include numerous, even hundreds, of providers, a uniform format is essential to manage the documentation.

The Model Form G – Schedule of Providers (Appendix G) is included to assist in this process. To this end, it is the responsibility of the group representative to gather these data elements and supporting documentation for each provider to be included in the group, even when such documentation may be on file with the Board in another appeal (*e.g.*, the underlying individual appeal, another group appeal). Failure to submit the requisite documentation for one of the providers may result in the dismissal of that provider from the group.

Finally, in conducting an *initial* format review, it is unnecessary for the Medicare contractor to comment on whether jurisdictional problems exist for any given provider or to identify every potential default in documentation.

20.1.4 The Schedule and Supporting Documentation Must Correspond

Submit a corresponding document for each entry on the schedule of providers (except column C). Reference Model Form G – Schedule of Providers (Appendix G) for layout of OH CDMS data fields and Rule 21 for content requirements.

Example: Exhibit 1A will correspond to line 1, column A and will contain a copy of the final determination for the first provider. Exhibit 2A will correspond to line 2, column A, and will contain a copy of the final determination for the second provider. Exhibit 1B will correspond to line 1, column B and will contain a copy of the appeal request in which this issue was initially raised for the first provider. Exhibit 2B will correspond to line 2, column B and will contain a copy of the appeal request in which this issue was initially raised for the second provider. When the documents are collated, each Provider's documents should be placed together. This means that all of the documents, final determination hearing request, the adjustment report, transfers, letters of representation should be placed together: 1A-the final determination; 1B-the hearing request; 1D-the adjustment report; 1G-the transfer request and 1H-the letter of representation should all be collated together.

Rule 21 Content for Schedule of Providers and Supporting Documentation for Group Cases that Are Not Fully Populated in OH CDMS

The schedule of providers must include all providers in the group and provide the associated documentation to support jurisdiction of the participating providers. The schedule has two parts,

a summary page with columns A-G and supporting documentation numbered according to the corresponding tabs A-H.

21.1 General Information

Enter basic information about each participating provider including the following:

- Sequence Number
- Provider Number
- Provider Name and Provider Location (City, State)
- Appealed Period (FYE, FFY, etc.) and impacted cost reporting periods ("CRPs"), if applicable.
- MAC Name/Code

The remaining entries in the schedule are addressed in separate sections below.

21.2 Date of Final Determination

21.2.1 Schedule – Column A

List date of final determination. If the final determination being appealed is a revised NPR, include an "(R)" after the date.

21.2.2 Documentation – Tab A

A copy of the final determination you are appealing:

- For a NPR appeal, submit the dated NPR cover page(s). Do not submit the entire NPR.
- For a revised NPR appeal, submit the dated revised NPR cover page(s). Do not submit the entire revised NPR. *See* Rule 7.1.2.1 for additional documentation requirements for appeals filed from a revised NPR.
- For appeals of Federal Register notices, submit all relevant pages of the Federal Register notice involving the issue being appealed. A global Tab A should be submitted for all participants rather than including Tab A for each provider. Do not submit the entire Federal Register notice.
- For appeals of other final determinations (*e.g.*, exception and exemption denials, Quality Reporting reconsideration denials, etc.), submit a copy of the final determination being appealed. (*See* Rules 7.1.2.2 – 7.1.2.5.)
- For appeals of the Medicare contractor's failure to timely issue an NPR, submit a copy of:
    - evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and

- evidence of the Medicare contractor's acceptance of the as filed or amended cost report under appeal. (*See* Rule 7.5.)

21.3 Date of Hearing Request

21.3.1 Schedule – Column B

Enter the date on which the original hearing request was filed with the Board (*see* Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request (*see* Rule 6.2.1), also enter the date that the request to add the issue was filed.

- If the appeal request was filed prior to August 21, 2008, the date of filing is the postmark date. *See* 42 C.F.R § 405.1801(a)(2007).
- If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the Board. *See* 42 C.F.R. § 405.1801(a)(2008).

21.3.2 Documentation – Tab B

A copy of the relevant pages from the initial appeal request (Model Form A or E) ***and*** the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (*e.g.*, USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

21.4 Number of Days

21.4.1 Schedule – Column C

Calculate the number of days between the issuance of the final determination at issue (*without* the 5-day presumption in 42 C.F.R. § 405.1801) and the date the hearing request for the issue was filed. For appeals filed on or after August 21, 2008 only, where the issue under appeal was added to the individual appeal subsequent to the original appeal request, include a second calculation for the number of days between the issuance of the final determination at issue (without the 5-day presumption) and the date the add request was filed. *See* 42 C.F.R. § 405.1835(c)(3).

21.4.2 Documentation – Tab C

It is unnecessary to submit documentation under a Tab C unless you are presenting evidence: (a) that you received the final determination more than 5 days after issuance; or (b) that the deadline to file an appeal with the Board is extended pursuant to 42 C.F.R. § 405.1801(d)(3).

21.5 Audit Adjustment Number

21.5.1 Schedule – Column D

Identify the audit adjustment or determination/authority challenged.

21.5.2 Documentation – Tab D

Provide a copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available. Submit any additional information needed to support jurisdiction or appropriate claim for the appealed issue. (*See* Rule 7.2.) If applicable, also provide support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

21.6 Amount in Controversy

21.6.1 Schedule – Column E

Identify the amount in controversy (reimbursement effect). (*See* Rule 6.4.)

21.6.2 Documentation – Tab E

Provide a calculation if the reimbursement effect is different from the audit adjustment.

21.7 Prior Case Number(s)

21.7.1 Schedule – Column F

If the issue was originally filed in another case, individual or group, list such case number. If the provider has participated in more than one group, whether through transfer or restructuring, include each case number in which the provider has participated in order to identify the full history of transfers. If the provider was directly added to the group appeal, indicate “Direct Add.”

21.7.2 Documentation – Tab F

No corresponding documentation required but see Tab G below.

21.8 Dates of Direct Add/Transfer

21.8.1 Schedule – Column G

For each case number identified in Column F, identify the date the issue was transferred from each respective case to the next case in order to identify the full history of transfers. The transfers must be identified in chronological order (earliest to latest).

21.8.2 Documentation – Tab G

The letter or Model Form transferring the issue from the individual appeal to a group appeal, as well as any subsequent transfer to a second or third group must be placed under this tab. If the cases were restructured, include a copy of the request to restructure and the Board's letter restructuring the case. The letters should be placed under the tab in chronological order (earliest to latest) to correspond with the schedule of providers. The dates of the letter(s) must match the dates recorded in column G of the schedule of providers. (*See* Rules 16, 17 and 18.)

21.9 Representation Letter

21.9.1 Schedule – Not applicable.

21.9.2 Documentation – Tab H

Include the letter of representation which must reflect the provider's fiscal year under appeal in this case and the issue. (*See* Rule 5.4.)

Rule 22 Medicare Contractor Review of Group Schedule of Providers

The lead Medicare contractor is responsible for reviewing the schedule of providers and the associated jurisdictional documentation. This review must be completed, with written notice to the Board of the lead Medicare contractor's findings on jurisdiction, within 60 days of receipt of the final schedule of providers (note: when the group is fully populated in OH CDMS, receipt occurs upon notice that the group is fully formed). If minor deficiencies in documentation are identified, the Medicare contractor is encouraged to contact the group representative to provide the opportunity to cure the submission.

Where the review of the group schedule of providers and jurisdictional documentation is done from a traditional schedule, the lead Medicare contractor must forward a copy of the final schedule of providers (without supporting documentation) to the Board along with a cover letter verifying its position that the issue is suitable for a group appeal and whether any impediments exist. Where the review of the participating providers is done based on the summary of providers and jurisdictional documentation within OH CDMS, the Medicare contractor must identify the date of its review and need only submit its letter of findings.

If a jurisdictional challenge is to be filed, that correspondence must be filed separately in OH CDMS.

PART II:
PRE-HEARING PROCEDURES

Rule 23 Proposed Joint Scheduling Orders ("PJSO") and Preliminary Position Papers

COMMENTARY:

The Board is continuing to offer two briefing options: (1) each party filing a preliminary position paper; OR (2) the parties jointly establishing deadlines through a PJSO. Effective August 29, 2018, the Board made rule changes for both options as noted below.

Option 1 – Preliminary Position Papers:

Prior to August 29, 2018, the parties exchanged full copies of the preliminary position paper with each other, but provided the Board only a copy of the cover sheet, listing of exhibits, and good faith statement. However, following the implementation of OH CDMS in August 2018, each party is now required to file a ***complete*** preliminary position paper with the narrative, listing of exhibits, and copies of all exhibits. As the Board now obtains a full copy of each party's preliminary position paper, which is required to have the fully developed position and identification of the controlling authority needed to support ***each*** issue in the appeal, final position papers are optional for new appeals filed on or after August 29, 2018 (*i.e.*, the effective date of the prior Rules change).

The filing of final position papers remains mandatory for all appeals that were filed prior to August 29, 2018.

For all appeals filed prior to August 29, 2018, final position paper deadlines will be established in the Notice of Hearing. For cases with optional final position paper filing requirements (*i.e.*, cases filed on or after August 29, 2018), parties may elect to submit a final position paper if they believe it will be useful to narrow or resolve the issues remaining in dispute, update legal authorities, etc. If the final position paper is not submitted by the deadline, the party will be limited to its initial arguments and documentation. Cases with mandatory position paper filing requirements are subject to dismissal under Rule 27.1, if the final position paper is not timely filed.

Option 2 – Proposed Joint Scheduling Order:

The PJSO was implemented in 2008 to provide more flexibility in the prehearing process. For PJSOs filed on or after August 29, 2018, the parties will continue to set timeframes for the exchange of documentation in order to resolve an appeal prior to the filing of a position paper. However, under the new PJSO rules, the Board will not track any deadlines prior to that of the preliminary position paper. The deadlines the parties set for preliminary position papers to be exchanged, if the case is not resolved, will be deemed a Board deadline, subject to 42 C.F.R. § 405.1868 and Rule 23.4. The Board will set the actual hearing date and associated final position paper deadlines consistent with Rule 24.4.

23.1 Duty to Confer

The regulations give the Board broad authority and flexibility to establish procedures. The regulation at 42 C.F.R. § 405.1853 directs the parties to expeditiously attempt to both resolve specific factual or legal issues and reach stipulations. To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:

- Agree to a proposed joint scheduling order, which is a detailed prehearing schedule setting timeframes for prehearing activities (such the exchange of documentation) and culminating with a deadlines for the parties to file preliminary position papers. The Board will not track any deadlines that occur prior to the deadlines for filing the preliminary position papers. Further, unless the parties expressly and jointly waive them, the Board will establish filing deadlines for optional final position papers based on the actual hearing date, *see* Rule 27. The PJSO is based on the parties' analysis of the development needed for the case. The PJSO is subject to Board approval. (*See* Rule 24)
- If the parties do not elect the PJSO process, they must file preliminary position papers and follow the timelines established by the Board in its acknowledgement letter.

Upon receiving an appeal request, the Board will send an acknowledgement letter establishing the filing due dates. By the first filing date, the parties file with the Board either a PJSO or a preliminary position paper.

23.2 Proposed Joint Scheduling Order

A PJSO may be filed in lieu of the provider's preliminary position paper if the parties reasonably believe the case may be resolved without briefing or may be considerably narrowed through partial resolution prior to briefing. A PJSO is a written scheduling plan covering all prehearing dates, except the final position paper due dates which will be set by the Board. The PJSO also establishes a proposed month and year of the hearing if the parties are unable to fully resolve the issues. The PJSO must be signed by both parties. *See* Rule 24 for specific content requirements.

23.3 Preliminary Position Papers Required if PJSO Is Not Executed

If the parties do not jointly execute and file a PJSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure full development of the parties' positions in order to foster efficient use of the administrative review process. The due date timeframe is set to give the parties the optimal opportunity to ***fully*** develop their case. Because the date for adding issues will have expired and transfers are to be made ***prior to*** filing the preliminary position papers, the Board requires preliminary position papers to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (*e.g*., subsequent case law or documents were unavailable through no fault of the party offering the evidence). *See also* Rule 25.2.3 addressing documents omitted or unavailable when the preliminary position paper is filed.

23.4 Failure to Timely File

The provider's preliminary position paper due date will be set on the same day as the PJSO due date. Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, the Board will dismiss the case. If the Medicare contractor fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.

23.5 PJSO and Preliminary Position Paper Extension Requests

Requests for extensions for filing a PJSO or preliminary position paper must be filed ***at least three weeks before the due date*** and will be granted only for good cause. If the Board has not notified the moving party[ies] before the due date that an extension was granted, and a PJSO or position paper is not timely filed, the Board will dismiss the appeal in accordance with Rule 23.4.

23.6 Miscellaneous Motions Filed Prior to PJSO or Position Paper Deadline

Matters pending before the Board that have not yet been completed or ruled upon (such as transfer requests, requests for abeyance, expedited judicial review, mediation, jurisdictional challenges, discovery, or other motions) will not suspend these filing requirements. If a motion or request is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with all filing deadlines.

If an issue(s) or the case is not timely addressed as required in this Rule because the parties have relied on an incomplete action or a pending request that has not yet ruled upon, it is subject to dismissal at any time during the proceedings.

COMMENTARY:

The Board expects requests for extension for filing to be rare and based on compelling reasons. For example, delay in finalizing a PJSO because the parties delayed conferring until shortly before the due date would not be considered good cause.

Rule 24 PJSO Content and Board Acceptance

24.1 General

A PJSO is a written scheduling plan covering all pre-hearing actions needed for development and resolution of the issues in the appeal. It also establishes preliminary position paper deadlines and a month and year of the proposed hearing in the event the issues cannot be fully resolved. The Board will establish the actual hearing date and the associated final position paper due dates.

When a PJSO is filed, every issue in the appeal must be addressed in accordance with the requirements below. This rule requires a detailed schedule of actions to resolve each issue appealed up to and including the hearing. These include a discussion of material facts, legal positions on questions of law, data exchange dates, etc. Failure to comply may result in dismissal of any issue that does not comply. (*See* Rule 41.2.)

If a provider intends to transfer an issue to a group appeal, the transfer ***must*** be complete by the PJSO filing date. If no group is available for transfer by the PJSO filing date, the PJSO for that issue must fully comply with the content requirements in Rule 24.2. If the transfer is not complete and the issue is not addressed as required by Rule 24.2, the issue is considered abandoned and dismissed from the case.

NOTE: A statement that an issue will be transferred at a future date is not in compliance. Therefore, ensure your groups are timely established in order to timely transfer issues prior to the PJSO deadline.

24.2 Format and Content of PJSO

The PJSO must address the following items:

A. Resolved Issues

Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. Conditionally Resolved Issues

For each conditionally resolved claim, provide a brief statement of the issue and describe the conditions on which resolution is based, including dates, actions, and audit methodologies required by the parties.

Example: Issue 1 is whether the provider's Medicaid eligible DSH days were adequately documented – the issue is conditionally resolved based on the Medicare contractor's agreement to reopen the issue.

C. Unresolved Issues

For each claim not resolved, provide a brief statement of the issue that addresses the following points:

- Identify the material facts and indicate whether they are disputed.
- If the claim cannot be resolved because of a question of law, state each party's legal position and the authorities relied on.
- Identify the documentation exchanged to date.
- If the parties expect the case to require discovery or a voluntary exchange and analysis of data, create a detailed timetable/schedule for that exchange. This schedule will supersede the timelines in the regulations, as permitted by 42 C.F.R. § 405.1853(e)(3).
- Once the PJSO is approved by the Board, the parties may modify PJSO deadlines by joint agreement. A modification of the hearing date, preliminary position paper due dates or final position paper due dates requires Board approval and a showing of good cause. For other deadlines, it is not necessary to file modifications with the Board unless a dispute arises that requires Board action.

D. Proposed Hearing Date

Identify a mutually agreed upon month and year for the hearing.

E. Signatures

Both the provider and Medicare contractor representatives must sign the document.

24.3 Board Response to PJSO

24.3.1 Issuance of Notice of Hearing

Unless the Board notifies the parties that the PJSO is rejected, the Board will issue a Notice of Hearing via email that sets the hearing date and final position paper due dates. The Board will make every effort to accommodate the requested hearing month and year. Note that the Board typically will not schedule a case less than a year after the filing of the appeal unless a special circumstance exists. The Board, however, will consider accelerated hearing requests (*see* Rule 31) at any time.

The scheduling of a hearing date on or after the requested month/year obligates the parties to comply with their agreed deadlines. Any deadlines not addressed by the PJSO (such as discovery, subpoenas, etc.) will be governed by the Board's Rules or the regulations unless the Board advises otherwise. Establishment of a hearing date based on the PJSO submission does not waive any party's right to object, or the Board's authority to take action, on matters not in compliance with the Rules or law (*e.g.*, duplicate issues, improper group, untimely filing of appeal, abandonment of issue or defense, etc.).

If the case representative does not receive a hearing notice within 30 days following the submission of a PJSO, the representative should contact the Board to ensure it was received and processed.

24.3.2 Rejection of PJSO in Whole or in Part

The Board may dismiss an appeal, dismiss an issue, require a preliminary position paper or take other appropriate action for failure to comply with this Rule.

24.4 Failure to Meet PJSO Deadlines

The Board will not track the PJSO agreed upon deadlines (*e.g.*, document exchange) prior to that of the preliminary position paper but the Board expects the parties to adhere to the schedule. If deadlines are missed and the parties cannot reach agreement for a modification or if you believe the other party is not acting in good faith, contact the Board. The Board will return the case to the traditional position paper briefing track and accelerate the hearing, if necessary.

The deadlines that the parties set for preliminary position papers to be exchanged, if the case is not resolved, will be deemed a Board deadline. The Board will also set the actual hearing date and associated optional final position paper deadlines. All Board deadlines are subject to the provisions of 42 C.F.R. § 405.1868.

Rule 25 Preliminary Position Papers

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable sub-section.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

25.1.2 Medicare Contractor's Responsive Position Paper

The Medicare contractor's preliminary position paper must:

A. Identify any jurisdictional impediments not previously raised, although jurisdictional challenges must be filed as separate submissions. (*See* Rule 44.4.)

B. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

C. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- Identifies which material facts or legal principles relied on by the provider are undisputed or which material facts the Medicare contractor is without sufficient knowledge to agree with or dispute.
- States the basis for the disputed facts and legal principles.
- Identifies any additional documentation required for resolution.
- States the material facts that support the Medicare contractor adjustments.
- Identifies the controlling authorities (*e.g.*, statutes, regulations, policy, or case law) supporting the Medicare contractor's position.

- Provides a conclusion applying the material facts to the controlling authorities.

D. Comply with Rule 25.2 addressing Exhibits.

25.1.3 Provider Response to Medicare Contractor Position Paper

A. Address rebuttal or Medicare contractor arguments not previously addressed.

B. Attach documentation not previously furnished with the provider's preliminary position paper that is responsive to arguments raised by the Medicare contractor in its responsive preliminary position paper.

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (s*ee* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

1. Identify the missing documents;

2. Explain why the documents remain unavailable;

3. State the efforts made to obtain the documents; and

4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

COMMENTARY:

Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

25.3.1 Size, Spacing, Binding, Tabbing, and Numbering of Position Papers

While the expectation is for parties to upload position papers in OH CDMS, the following formatting requirements apply whether filing an electronic version or hard copy version.

A. Size – Use 8 ½ x 11 paper. Use a typeface that is 10 points or greater.

B. Numbering –

1. Position Papers – Every page of the position paper shall be numbered in the bottom center of each page. Every page of each exhibit shall be Bates numbered in the lower right corner of each page in a minimum of 12 point font.

2. Exhibits – The Bates numbering shall be sequential starting with the first page of the first exhibit continuing *through the last page of the **last** exhibit*, including all exhibits submitted *prior to* the closing of the record by the Board. If the placing of Bates numbering in the lower right corner will obscure the content of the exhibit, the Bates numbering shall be placed in another corner of the page that will not obscure the content of the exhibit.

COMMENTARY:

For example, if the Provider attached Exhibit P-1 through P-4 to its preliminary position paper, then the Bates number for Exhibit P-1 would begin at P0001 and the sequential numbering would continue through the end of Exhibit P-4. If Exhibit P-4 ended at P0121 and the Provider *subsequently* files Exhibit P-5 containing ten (10) pages (*e.g.*, as an attachment to its final position paper), then Exhibit P-5 would start at P-0122 and the sequential numbering would continue through the end of Exhibit P-5 with P0131. Similarly, if the Provider files Exhibit P-6 at the hearing or, in response to a Board request, subsequent to the hearing, then Exhibit P-6 would start at P-0132 and continue through the end of Exhibit P-6.

C. Hearing Exhibit Identification – Separate and number exhibits by tabs with identification as either provider exhibits (P-1, P-2) or Medicare contractor exhibits (C-1, C-2). Upload each exhibit separately into OH CDMS.

D. Legible Copies – Exhibits must be legible.

E. Listing of Exhibits – List each document attached as an exhibit and indicate the tab number.

F. Binding – For hard copy filings such as the additional Board copies submitted for hearing, the binding must be suitable for the thickness of the position paper. The document should easily remain open with the text unobscured by the binding. Because of space limitations, do not send position papers in three ring binders.

25.4 PJSOs Filed after the Preliminary Position Papers

If the parties initially filed preliminary position papers instead of a PJSO (*see* Rule 23), they may nevertheless file a PJSO after the preliminary position papers are filed. Generally, such PJSOs will supersede the rules establishing other discovery/documentation exchange deadlines established by the Board but will not postpone a scheduled hearing date unless approved by the Board.

Rule 26 Prehearing Discovery

26.1 No Filing of Discovery Requests/Responses Except in Disputes

The parties are expected to voluntarily exchange documents relevant to the issues pending in the appeal. However, to the extent that discovery may be necessary, discovery requests and any responses thereto are **not** to be filed with the Board unless there is a discovery dispute.

26.2 Initial Discovery Request

The party requesting discovery must file a written request for discovery with the entity from which discovery is requested and on the opposing party; it is **not** to be filed with the Board.

The deadlines for requesting discovery are established by either:

- The timelines set forth at 42 C.F.R. § 405.1853. The Board may extend or modify these dates upon written motion; or
- A PJSO approved by the Board, including the parties' written modifications.

A discovery request must include a certificate of service that includes:

- The verifiable date that the request was served (*e.g.*, overnight mail service tracking information for each individual notified of the request);

- The identity of each individual receiving a copy of the request, including the mailing address used; and
- The dated signature of the representative of record.

26.3 Motions to Compel Discovery or for Protective Orders

Motions to compel or for a protective order must comply with the requirements of 42 C.F.R. § 405.1853(e)(5) and must include:

- A copy of the discovery request, including the certificate of service served with the discovery request.
- A copy of the disputed response(s), if any.
- An explanation for the need for relief and the legal basis.
- A declaration by the party requesting relief that he/she has conferred with the opposing party to discuss the efforts to resolve or narrow the discovery dispute. Documents reflecting these attempts may be attached.

26.4 Response

Unless the Board imposes a different deadline the opposing party or applicable nonparty must file a response to a motion to compel or motion for a protective order within 15 days from the date the motion is received.

26.5 Use of Discovery at the Hearing or as an Exhibit to a Position Paper

Generally, evidence elicited through discovery may be designated as an exhibit or read into the record of the hearing. If the discovery is to be used at the hearing as evidence or is attached to the position paper as an exhibit, submit those portions relevant to the issue plus the signature page and cover page to indicate the source of the excerpt. The opposing party may submit other portions of the same document in rebuttal. Evidence elicited through discovery may be used at the hearing for impeachment without prior notice or designation, *provided the entire document is available at the hearing*. *See* Rule 35.6 for use of deposition testimony at a hearing.

Rule 27 Final Position Papers

27.1 General

The Board will set due dates for the final position papers in its Notice of Hearing, generally 90 days before the scheduled hearing date for the provider; 60 days for the Medicare contractor; and 30 days for provider response (optional).

- ***Optional For New Appeals Filed On or After August 29, 2018***.—For new appeals filed on or after August, 29, 2018, the parties are required to file a ***complete*** preliminary

position paper (*see* Rule 25.3). Therefore, for appeals filed on or after August 29, 2018, the final position paper is an ***optional*** supplemental filing, intended to hone the issue(s) if necessary, but is not required. If no paper is submitted, the arguments related to the issue(s) under appeal will be limited to those set forth in the preliminary position paper.

- ***Remains Mandatory For Appeals Filed Prior to August 29, 2018***.—For appeals filed prior to August 29, 2018, the final position paper remains a required filing, and *failure to timely file the final position papers may result in dismissal of the case*. ***Exception***: If, ***before*** the final position paper deadline, a provider files a withdrawal request, or the parties file a *fully executed* Administrative Resolution withdrawing the case, and the Board has not yet officially sent notice acknowledging closure of the case, the parties are not expected to file final position papers as the withdrawal is self-effectuating (*see* Rule 46).

27.2 Content

The final position paper should address each issue remaining in the appeal. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.

27.3 Revised or Supplemental Final Position Papers

A party may also file a revised or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties. Notwithstanding, the Board encourages revised or supplemental position papers when they promote administrative efficiency and further *narrow* the parties' positions or provide legal development (such as new case law) that has occurred since the final position paper was filed. Prior to filing such papers, the parties should contact each other to discuss the anticipated substance of such papers and anticipated objections. If a revised or supplemental position paper is filed to further refine or narrow the issues, the opposing party may file a rebuttal or reserve such rebuttal for hearing.

27.4 Expanding Scope of Arguments at the Hearing or in Revised or Supplemental Final Position Papers Is Prohibited

If at hearing or through a revised or supplemental position paper, a party presents an argument or evidence *expanding* the scope of the position papers, the Board may, upon objection or its own motion, exclude such arguments or evidence from consideration.

Rule 28 Witness List

At least thirty (30) days prior to the hearing date, each party must file with the Board and serve on the opposing party a witness list. The list must identify each witness, the witness's relationship to the party, and the nature of the witness's testimony. A party's failure to timely file

a witness list will result in the Board taking appropriate actions under 42 C.F.R. § 405.1868 (*e.g.*, excluding witnesses).

If a party intends to qualify a witness as an expert (*see* Rule 34), the witness list must identify the witness as an intended expert, designate his/her field of expertise, and state the subject of the testimony. The party intending to offer expert testimony must file with the Board and serve on the opposing party the following documents at least 30 days in advance of the hearing date:

- a copy of the expert's resume, and
- a report from the expert, which summarizes his/her anticipated testimony (background facts, principles and/or opinions) and the bases supporting such testimony.

Refer also to Board Rule 35.3 for the Rules addressing late filed exhibits.

Rule 29 Status / Pre-Hearing Conferences

The Board may conduct a status conference at any time on the Board's own motion or at the request of either party to the Board Advisor. (*See* 42 C.F.R. § 405.1853(c).) Before a scheduled hearing date, the Board may schedule a status (pre-hearing) conference to, among other reasons, narrow issues and discuss logistics to facilitate the hearing. The parties are expected to have discussed the following with each other prior to a pre-hearing conference with the Board:

- Issues remaining in the appeal;
- Amount in controversy for each remaining issue;
- Status of settlement discussions and potential for further settlement for each remaining issue;
- Stipulations;
- Evidentiary or discovery issues;
- Witnesses, including the necessity for and extent of expert testimony;
- Documentary evidence;
- Whether a request will be made for one or more witnesses to appear by video conference or telephone, or for the Board to conduct the entire hearing by video conference or telephone;
- Estimated length of hearing and, if a party desires to conduct part of the hearing by video conference or telephone, the estimated length of that portion of the hearing;
- Audio and visual needs; and
- Accommodations for disabled visitors.

PART III:
HEARINGS AND DECISIONS

Rule 30 Hearing Dates and Postponements

30.1 Notice of Hearing

The Board will issue a Notice of Hearing setting the hearing date and final position paper due dates. The hearing date established by this notice will serve as the date that governs deadlines for final position papers (Rule 27.1); discovery (Rule 26 and 42 C.F.R. § 405.1853(e)); subpoenas (Rule 47 and 42 C.F.R. § 405.1857(a)); witness lists (Rule 28); and other deadlines under these rules.

30.2 Dismissing for Failure to Appear

Except for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing.

30.3 Submitting a Motion to Postpone the Hearing

30.3.1 General

The Board will consider, but will not routinely grant, any motion requesting to postpone a scheduled hearing date. The Board expects the parties to be ready for hearing. The representation that a settlement is imminent or probable will not guarantee a postponement. A recent change in representatives or the late filing of a motion will generally not warrant the Board granting a postponement for either party. The Board expects the parties to be diligent in planning and preparing for hearing and disfavors last minute postponement requests. Accordingly, the Board expects motions for postponement to be filed *no later than 20 days prior to hearing,* except when a party establishes good cause.

30.3.2 Request Content

A motion for postponement must be filed in compliance with Rule 2 and contain the following:

- The reason the party[ies] are not ready for hearing.
- An explanation (including dates and events) of how the parties have worked together to settle or narrow the issues.
- A list of the actions needed to be ready for hearing.
- Whether both parties concur in the Motion.
- A proposed month and year in which to reschedule the case.

NOTE: A motion for postponement pending before the Board that has not yet been completed or ruled upon will not suspend either the hearing date or any pre-hearing filing deadlines (*e.g*., position papers, witness lists). If a motion for postponement is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with the hearing date and all filing deadlines.

30.3.3 Motions to Postpone Due to Scheduling Conflicts

If upon receipt of the Notice of Hearing, there is a scheduling conflict, or an unforeseeable conflict later arises, it is expected that the requesting party will file a motion for postponement with the Board as soon as possible. The moving party shall brief the details of the conflict (*e.g*., the name and case number and the court where an appearance is required) and, if possible, include suggested nearby dates for rescheduling the hearing. The Board will promptly consider filed requests for postponement to reschedule the case to a nearby date (whether earlier or later than the scheduled date).

30.3.4 Opposing a Postponement Request

If a motion to postpone is filed and a party opposes the motion, then the opposing party must file its response within the applicable time frame:

- If the request for postponement is filed no less than twenty (20) days prior to the hearing date, then the opposing party's response is due within two (2) business days.
- If the request for postponement is filed less than twenty (20) days prior to the hearing, then the opposing party's response is due as soon as possible because the Board will not wait a specified period of time before ruling on the postponement request.

30.4 Consolidated Hearings

The Board will consider consolidated hearing requests for cases that have identical legal issues. The provider should make this request, in writing, and indicate if the opposing party agrees with the request. The Board requests that the consolidation request be made prior to the hearing date, but will also entertain requests on a case-by-case basis to consolidate cases for a single decision post-hearing.

Rule 31 Accelerated Hearing Date

31.1 Request for Accelerated Hearing

When a party is fully prepared to present its case and is unable to administratively resolve the case, it may request that the hearing for the case be set at the earliest possible date (or within a

specified range of dates). The request shall provide a status report on the case (*see* Rule 29) and demonstrate that:

1. The case has no impediments to a hearing (such as outstanding motions or discovery requests); and

2. The documentation exchange between the parties is ***complete*** (including but not limited to providing copies of any expert reports and underlying documentation to the extent an expert is being called as a witness).

The request must also state whether the non-moving party concurs. If granted, the Board may establish such deadlines or impose such conditions as may be appropriate.

31.2 Firm Hearing Date

If the Board grants a request for an accelerated hearing date, the parties are expected to meet any deadlines that may need to be accelerated to accommodate the accelerated date (*see* Rule 30). Accelerated hearing dates will be considered firm.

After the Board approves an accelerated hearing date, the parties must notify the Board if the basis for the accelerated hearing changes and/or an impediment arises (*e.g.*, an evidentiary dispute involving previously undisclosed or unknown material evidence; a need to conduct discovery). The parties' notice must also advise the Board whether the parties concur in maintaining the accelerated hearing date. Based on the information from the parties, the Board may take remedial action such as holding a pre-hearing conference, issuing a Scheduling Order, and/or rescinding the accelerated status and postpone the hearing.

Rule 32 Methods of Appearance

The parties' representatives and witnesses are expected to appear at the time, date, and forum of the schedule hearing unless the Board approves a motion to postpone the hearing.

32.1 In-Person Hearing

Board hearings are held in-person unless the Board designates an alternative forum. Except as the Board may otherwise designate, Board hearings are held at the location set forth in correspondence from the Board (*e.g.*, Notice of Hearing).

32.2 Telephone Hearing

The parties may request to present all or part (*e.g.*, witness testimony) of their case by telephone. Generally, an appropriate case to hear in its entirety by telephone would involve a strictly legal issue, or a case with few disputed material facts and witnesses that would require minimal reference to exhibits. A telephone hearing should not exceed 2 hours.

Remote telephonic witnesses will be asked to identify any other individuals and documents with them during the testimony. Upon objection, or upon the Board's own motion, any individuals who are not testifying may be required to leave the room. It is the responsibility of the party calling a remote telephonic witness to ensure that the witness has, available for reference, all of both parties' organized and labeled exhibits and each party's latest filed position paper (including revised or supplemental final position papers, if applicable).

32.3 Video Hearing

The Board may determine that a hearing by video is appropriate and, if so, will notify the parties.

Alternatively, the parties may request to present all or part (*e.g.*, witness testimony) of their case via video conferencing. The Board approves requests for video hearing (in part or in whole) on a case by case basis taking into account the nature of the case and expected testimony, and whether both parties concur in the use of the alternative forum.

Remote video witnesses and representatives must identify all other individuals and documents with them during the hearing. Upon objection, or upon the Board's own motion, any individuals who are not currently testifying may be required to leave the room where the remote video witness is testifying. It is the responsibility of the party calling a remote video witness to ensure that the witness has, available for reference, all of both parties' organized and labeled exhibits and each party's latest filed position paper (including revised or supplemental final position papers, if applicable).

32.4 Record Hearing

In cases involving only legal interpretation or very limited fact disputes, and where both parties agree that the case is appropriate for a record hearing, the Board may approve the parties' request to submit their case only on the existing written record. Generally, record hearings are inappropriate when material facts are in dispute and/or the credibility of witnesses may be at issue. After approving the request, if the Board concludes that a case is not suitable for a record hearing, the Board will reset the case for an in-person, video, or telephonic hearing.

To be approved for a record hearing, the record must be substantially complete and well organized. Position papers must be filed by both parties and clearly reference specific evidence on which the parties rely, including the exhibit number and page. The Board generally will deny the parties' request for a record hearing if stipulations regarding all undisputed facts and principles of law are not submitted with the parties' request.

Upon approval of a record hearing, the Board will issue a Notice of Record Hearing to notify the parties of a date for the final closure of the record. No additional evidence or arguments may be presented after such time, except on written motion demonstrating good cause for the late filing.

Rule 33 Conduct of Hearing

33.1 General

Board hearings are adversarial but are not restricted by formal rules of judicial procedure or evidence. The following procedures are intended to facilitate the full presentation of the facts and arguments relevant to disputes.

33.2 Sequence

Generally, the provider presents its case first. The parties may agree to a different order of presenting evidence or the Board may request a different order. In cases involving multiple issues, the parties may propose presenting the case issue by issue as opposed to each party presenting all of their issues consecutively.

33.3 Opening Statements

The parties should open with a brief statement to serve as a “road map” for the presentation. The parties should summarize the undisputed facts, the legal questions at issue, and the nature of the testimony and evidence they expect to present during the examination of their witnesses.

33.4 Witness Examinations

33.4.1 Availability

Any person present in the hearing room or via telephone or video conference is subject to being called as a witness without a subpoena. Each witness’s testimony will be sworn or affirmed. Unless the Board permits otherwise, persons on the witness list must remain present until excused or the hearing is adjourned.

If a party wishes to ensure a witness identified on the opposing party’s witness list will appear, the Board strongly encourages the parties to execute a written agreement that the witness will attend the hearing without the need for a subpoena. If no agreement can be reached, the party seeking the attendance of the identified witness may request that the Board issue a subpoena requiring the witness’s attendance at the hearing.

33.4.2 Order of Questioning

Unless the parties agree otherwise, the typical order of questioning is as follows, beginning with the provider’s witnesses:

- Direct (questioning by the representative calling the witness)
- Cross examination by the opposing representative
- Redirect (limited to follow up on cross examination questions)
- Board questions

- Follow up to Board questions by the representative calling the witness
- Follow up to Board questions by opposing representative

The Board may ask questions of the witnesses at any time during or after the representative's questioning. The Board may also expand the opportunities for further questioning of a witness. In certain circumstances, the Board may permit a witness to be recalled or the Board may call or recall a witness.

33.4.3 Direct Examination

Testimony should be based on the witness' personal knowledge and be confined to matters relevant to the issues in dispute. The Board generally permits hearsay; however, it will look to whether the circumstances indicate the hearsay is reliable or undisputed in determining what weight, if any, should be given the hearsay.

33.4.4 Cross Examination

On cross examination, the witness may be questioned on any exhibit or position submitted by the party calling the witness.

33.4.5 Rebuttal Witnesses

Rebuttal witnesses will be permitted at the discretion of the Board.

33.5 Closing Arguments

Closing arguments should be utilized to summarize how the legal authorities apply to the evidence elicited at the hearing. The parties may request to waive closing argument; however, the Board may require closing argument.

33.6 Adjournment of Hearing

Upon adjournment of the hearing, no further evidence may be submitted unless the Board asks for or authorizes additional evidence to be submitted post-hearing. (*See* 42 C.F.R. § 405.1851). However, the Board, on its own motion or by motion of a party, also has the discretion to reconvene a hearing to receive additional evidence or testimony.

Rule 34 Expert Witnesses

34.1 Expert Witness Defined

An expert witness is a person, who by virtue of his/her background, experience, or training has knowledge in a particular subject area outside the expertise of the decision maker sufficient that others may use their testimony to better understand or determine a fact at issue.

34.2 Expert Qualification

Expert qualification is appropriate for areas material to the dispute but in which the Board does not have expertise. The party presenting the expert must demonstrate that the expert is qualified in the designated area of expertise. The proposed expert is subject to questioning by the opposing party and the Board as to his/her qualifications. The Board does not recognize as an expert any witness whose areas of expertise is legal interpretation of Medicare cost reimbursement issues because it falls within the Board's area of expertise.

34.3 Expert Report

The expert must prepare a written report for submission to the opposing party's representative in accordance with Rule 28.

Rule 35 Hearing Materials

35.1 Board Copies of Position Paper

Parties are ***not*** required to submit additional copies of position paper(s) and exhibits that are populated in OH CDMS, unless directed to do so by the Board. If the Board requests that the parties furnish six (6) additional copies, those copies must be received at the Board ten (10) days before the hearing. Board members' copies should be designed for easy reference during the hearing and may be in loose-leaf binders but must otherwise meet all of the same requirements as for the original filing. Please notify your assigned Board Advisor when you send the copies.

35.2 Stipulations

35.2.1 General

A stipulation is an agreement regarding factual evidence or the application of law or policy. Stipulations become part of the record and require no further evidence. Typical matters for stipulation include substantive facts, background facts, a witness's work or educational history, or the procedural history of the case.

> Example 1: The parties stipulate that a transaction was a statutory merger under the laws of Georgia, [thus eliminating the need for proof from a Georgia legal expert but a dispute may remain as to what is the reimbursement effect of the merger.]
>
> Example 2: The parties stipulate that "the provider meets the requirements for an exception as an atypical provider under regulation x." [That stipulation does not preclude a challenge to whether the provider met the second part of the regulatory requirement to show that its excess costs were due to atypical services and costs.]

35.2.2 Procedure

While the Board encourages the parties to file written stipulations in advance of the hearing to assist the parties and Board members to prepare for hearing, oral stipulations may also be entered into the record during the hearing. Stipulations may be referenced in testimony or argument as needed. Stipulations may be withdrawn only on a showing of good cause.

35.3 Documentary Evidence

Except on agreement of the parties, documentary evidence relevant to fact disputes must be identified and exchanged by the deadline established in the PJSO or by these rules. The Board will not be responsible for supplementing any record with evidence from a previous hearing. All evidence submitted into the record, must be done by the parties.

The parties are encouraged to discuss whether there will be objections to exhibits prior to the hearing and attempt to work out differences. If the parties agree, exhibits may be added up to the time of the hearing. Generally, additional legal authorities or summaries will not be subject to these time limits. At the commencement of the hearing, the Board will ask the parties to identify their respective exhibits and will ask if there are any objections to the opposing party's exhibits. Upon objection or the Board's own motion, the Board will determine the propriety of permitting late filed exhibits, taking into account the reasons for the late filing and the requirements of Rules 23 through 27, and prejudice to the opposing party.

35.4 Visual Aids

35.4.1 Prepared Prior to the Hearing

The Board encourages the use of visual aids that facilitate presentation of evidence (charts, diagrams, large print copies, power point presentations, etc.). Visual aids should not contain material not previously submitted to the opposing party. The Board also requests that an 8 ½ x 11 copy of any visual aid be submitted to the opposing party and to the Board in advance of the hearing. For clarity in the record, a copy of a visual aid should be added as an exhibit at the hearing.

35.4.2 Creation of Visual Aids During a Hearing

A document camera is available during the hearing. If this or other tools are utilized in the hearing, the parties should make a statement summarizing the content of the writings made during the hearing for clarity of the transcribed record.

35.5 Summaries for Voluminous Records

35.5.1 Use of Chart or Summary Exhibit

Summaries and/or charts are encouraged whenever evidence is voluminous or the data is complex. Using Rule 1006 of the Federal Rules of Evidence as a guideline, and unless permitted by the Board, a party that wants the Board to consider the contents of voluminous

records or complex data may offer that evidence as an exhibit in the form of a summary or chart.

35.5.2 Filing and Service of the Summary Exhibit and Supporting Documents

The summary or chart offered as an exhibit, like other proposed exhibits, must be furnished to the Board and served on the other party. The party offering the summary or chart must supply the opposing party with copies of all supporting documentation upon which the summary is based, *sufficiently in advance of the hearing* to allow for review of the source data to determine the accuracy of the summary. Upon its own motion or the motion of a party, the Board may order that supporting documentation be filed as an exhibit in the record and/or be produced at the time of the hearing with clear cross-references within the summary.

35.6 Deposition Testimony and Interrogatories

Deposition testimony may be used at the hearings as if the deponent(s) were present and testifying. At least 10 days before the hearing, the party proposing to use deposition testimony must notify the opposing party and specify the pages and lines to be read. The opposing party may require the party offering deposition testimony to include additional excerpts from the deposition. Prior notice is unnecessary if the testifying witness is present and the deposition testimony is used for rebuttal or impeachment. Interrogatory responses may be used without prior notice.

35.7 Affidavits

Affidavits as to material facts in dispute will generally not be considered without an agreement by the opposing party because affidavits do not provide an opponent an opportunity to cross-examine. Affidavits are to be made on personal knowledge and be signed before an officer authorized to administer oaths (*e.g.*, a notary).

35.8 Prior Testimony Before the Board

Upon the parties' agreement and subject to the Board's approval, the transcribed testimony from a previous Board hearing may be admitted as evidence. The specific portions must be identified, copied (along with a cover page and certificate to indicate the source and date) and marked as an exhibit. It is not sufficient to merely reference another case number.

35.9 Transcript

The Board has a verbatim transcript made of each hearing. The cost of the hearing transcript for the official record is borne by the Board. The parties may contact the court reporter directly to obtain copies of the transcript at their expense.

Rule 36 Post-Hearing Submissions

36.1 General

A post-hearing brief may be submitted only if requested by a party or the Board at the close of the hearing. If requested, the Board will set the deadlines for the filing of post hearing briefs in OH CDMS. In accordance with Rule 35.1, the Board may require that six (6) additional hard copies of the post-hearing briefs be submitted.

36.2 Post-Hearing Submissions

36.2.1 Evidence

If additional information was requested by the Board at the adjournment of a hearing (Rule 33.6), only the evidence that was specifically requested may be submitted post-hearing.

36.2.2 Briefs

If requested by a party or the Board, post-hearing briefs should be similar to the closing argument (*see* Rule 33.5) in that the post hearing brief should cite the key testimonial and documentary evidence presented, and apply the controlling legal authority. The brief should contain citations to the transcript and the exhibits where appropriate. A post-hearing brief should not contain new information or evidence (*see* Rule 33.6) unless authorized by the Board. Additional authorities or summaries of the evidence presented are appropriate, however.

Rule 37 Board Decision

The Board decision is final and binding upon all parties to the hearing except as provided in 42 C.F.R. § 405.1871(b). Board decisions are available on the Board's website at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-decisions.

Rule 38 Quorum of the Board

A quorum of the Board is required to issue a hearing decision, but a quorum is not required to hold a hearing. (42 C.F.R. § 405.1845(d).) A provider may file a written request for a quorum of Board members to conduct a hearing. Every effort will be made to have a full Board available on the day of the hearing.

PART IV:
OTHER GENERAL RULES

Rule 39 Abeyance Requests

Abeyance suspends action on an appeal until specified events occur or conditions are met. There is no "right" to an abeyance; it is discretionary with the Board and is granted on a case-by-case basis for good cause. Generally, it is appropriate only for judicial economy or where the provider can demonstrate that the case will be resolved without a hearing upon the occurrence of specified conditions or events.

The party's request must be in writing and explain in detail why abeyance is appropriate. If the request is based on final disposition of another pending case, explain why the pending case is relevant and provide the following information on the pending case: the case caption, the case number, the court where the case is pending, and the status of the case.

The parties are required to notify the Board upon the resolution of the pending case or a change in the specified conditions or events that led to the abeyance. In the interim, the Board may require the requesting party to periodically file a status report.

Rule 40 Contact with the Board Staff

40.1 Do Not Directly Contact Board Members

Inquiries about a case or questions about the Board or its procedures should be directed to the Board Advisor or, if an Advisor has not been designated, to the staff at 410-786-2671. Do not call or email the Board members directly unless otherwise instructed and opposing parties are included in the contact.

40.2 Ex Parte Communications

40.2.1 Procedural Matters

Communications with Board staff regarding procedural matters are permitted and are not considered Ex Parte communications. (*See* 42 C.F.R. § 405.1868(f).) The Board's staff may contact parties at any time to discuss routine procedural or logistical matters, or to request status information about the case. Any discussions or requests which may affect a party's rights should be made with both parties present. If it is impractical to have both parties present when requests are made, the substance of the request or conversation must be communicated to the other party.

40.2.2 Substantive Matters

It is improper to communicate with the Board or its staff concerning the merits of a case pending before the Board unless all parties are included in the communication. All communications from any party or other person (including CMS, the Department of Justice, or the Office of the Inspector General) about a case pending before the Board must be in writing and must indicate that copies have been served on all parties. The Board will document and notify all parties of any improper communications. All written communications (except internal communications reflecting Board deliberations, which are privileged) become a part of the permanent record, including notations of any improper communications.

Rule 41 Dismissal or Closure

41.1 Parties' Motion

The Board will issue a written closure via email upon notice from the parties that the case has been resolved or withdrawn.

41.2 Own Motion

The Board may dismiss a case or an issue on its own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
- upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868);
- if the Board is unable to contact the provider or representative at the last known address; or
- upon failure to appear for a scheduled hearing.

Rule 42 Expedited Judicial Review

42.1 General

A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue prior to granting an EJR request (*see* Rule 44.5). In an appeal containing multiple issues, EJR may be granted for fewer than all the issues,

in which case the Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days *after it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.

42.2 Requests for EJR

Because an EJR request is time sensitive, the request for EJR is to be filed separately and clearly labeled. The request for EJR is not to be included in the text of another filing such as a jurisdictional brief or position paper and will not be considered filed if so included.

42.3 Content of the EJR Request

A provider or a group of providers must file a written request for EJR with a fully developed narrative that:

- Identifies the issue for which EJR is requested;
- Demonstrates that there are no factual issues in dispute;
- Demonstrates that the Board has jurisdiction;
- Identifies the controlling law, regulation, Federal Register notice, or CMS ruling that is being challenged; and
- Explains why the Board does not have authority to decide the legal question posted by the appeal.

In addition, for a group appeal, the EJR Request must include the following, to the extent they have not been previously filed:

- Confirmation that the group is fully formed in accordance with Rule 19.
- If Rule 20.1.2 applies, both the ***hard copy*** filing and electronic submission of the final schedule of providers including the schedule of providers and supporting jurisdictional documents for each provider. NOTE: If the ***hard copy*** jurisdictional documents are not tabbed and formatted in accordance with the Board's instructions, the Board will return them to the group representative for correction before considering the EJR request.

> **COMMENTARY:**
>
> Ensure that your EJR request ***clearly*** identifies the controlling law, regulation, Federal Register notice, or CMS Ruling under challenge.

42.4 Opposing an EJR Request

If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR request.

Rule 43 Mediation

43.1 General

Providers and Medicare contractors can resolve their dispute informally through the use of a form of alternate dispute resolution, *i.e.*, mediation. The Board's mediation program is a voluntary, flexible, and confidential process designed to facilitate resolution of issues and to narrow any remaining issues that are determined to proceed to hearing. Mediation sessions are conducted by trained mediators from the Office of Hearings. The role of the mediators is to improve communication by helping the parties articulate their positions and understand those of their opponent. The mediators assist resolution but do not render a decision or dictate a settlement. 90-95% of cases that are mediated have been resolved without a hearing.

43.2 Requesting Mediation

The provider can submit a request for mediation at any time in the appeal process. The provider and Medicare contractor must confer to ensure both parties are in agreement to pursue the mediation option and to reach agreement as to the specific issues to be addressed during mediation. The mediation request must include a jointly executed list of issues and the following attestation:

> The parties have reviewed the listed issues and reasonably believe that the disputed issues (1) are jurisdictionally proper; (2) do not involve conflicting interpretations of CMS regulations or policy; and (3) may potentially be resolved or narrowed through further discussion and a review of the documentation.

If the Office of Hearings staff agrees to mediate the case, the parties will be notified in writing that the case has been accepted into the mediation program and all pending due dates will be suspended. **The parties must continue to adhere to all due dates until written confirmation is received that the appeal has been approved for mediation.**

If a Medicare contractor refuses a provider's request to mediate, the provider may request an accelerated hearing if it is fully prepared to present its case. (*See* Rule 31.)

43.3 Scheduling a Mediation Session

Once the case has been approved by the parties for mediation, every effort should be made to mediate within 180 days of the acceptance into the mediation program. The Board staff will contact the parties to schedule the mediation. If the parties do not make a genuine attempt to schedule mediation within this time frame, the case will be removed from the mediation program, and due dates or position papers, etc. will be reestablished.

Once a case is scheduled for mediation, both parties must file with the mediators a short (one to two page) summary of their position on the issues to be mediated approximately 30 days before the scheduled mediation. The parties must also exchange all relevant documentation well in advance of the scheduled mediation. A lead spokesperson must be designated by each party at the mediation session.

43.4 Participating in a Mediation Session

Generally, the mediation session will take place at the office of the Medicare contractor. The parties are required to have in attendance at the session someone with the authority to resolve the matters at issue and sign the mediation agreement. The parties may be represented by counsel or a consultant. All proceedings at the mediation shall be confidential, including all resolution discussions.

At the mediation session, the mediators will typically ask the provider, as the moving party, to summarize its position first, after which the Medicare contractor states its position. Following these presentations, the mediators may also meet privately with each party to discuss the issues. If the parties voluntarily reach a resolution on some or all issues, they draft and sign a mediation agreement.

Rule 44 Motions

44.1 In Writing

All motions (including jurisdictional challenges) to the Board are to: (1) be made in writing, (2) set out the legal and factual basis supporting the motion, and (3) include supporting documentation. (*See* Rule 30.3 regarding requirements for requests to postpone a hearing.)

44.2 Duty to Confer

The moving party must summarize the efforts it made to contact the opposing party to discuss the merits of the motion and whether the opposing party will concur or oppose the motion. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. See sample language below.

> *I conferred with _____ [name and organization] concerning the foregoing_____ [specific motion/request] and ____ [he/she] _____ [does/does not] oppose the _____ [motion/request].*
>
> *I attempted to confer with _____ [name and organization] concerning the foregoing _____ [specific motion/request] by _____ [give specific details of attempts, for example, by leaving five telephone messages but was unable to discuss the matter.]*

44.3 Time for Filing Response

Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party. Refer to Rule 30.3.1 regarding specific time limitations to respond to

a motion to postpone a hearing and Rule 42.4 regarding specific time limitations to respond to an EJR request.

44.4 Jurisdictional Challenges – Timing

Jurisdiction may be challenged at any time. However, the Board requests that preliminary jurisdictional reviews be completed pursuant to the timeframes below.

44.4.1 Individual Cases

Consistent with the Medicare contractor's obligations in 42 C.F.R. § 405.1853(a) and Rule 25, the Board requests that the Medicare contractor preliminarily review the provider's claimed basis for jurisdiction and raise any identified jurisdiction challenges PRIOR TO **filing** the PJSO, if applicable, or PRIOR TO **filing** the Medicare contractor's preliminary position paper.

If a request for expedited judicial review ("EJR") is filed in an individual case, the Medicare contractor must file any jurisdictional challenge impacting the Board's review of that EJR request within five (5) business days of the filing of the EJR request. In this situation, consistent with 42 C.F.R. § 405.1842(e)(3) and Board Rule 42.1, the Board would then issue a Scheduling Order setting a deadline for the Provider's response (but no more than 30 days).

44.4.2 Group Cases

A. Within thirty (30) days of receipt of the Board's Acknowledgement of Group Appeal, the current Lead Medicare contractor must file a written statement with the Board addressing whether:

    1. the group complied with the initial group appeal filing requirements;
    2. jurisdiction (subject matter) is proper; and
    3. the issue is suitable for a group appeal. (*See* Rule 15.)

B. Within 60 days of receiving the final schedule of providers with supporting documentation, the final Lead Medicare contractor must file a statement regarding whether jurisdiction is proper for each provider in the group. (*See* Rule 22.)

EXCEPTION—If the final schedule of providers is filed concurrent with a request for expedited judicial review ("EJR") or 60 days has not yet transpired between the filing of the final schedule of providers and the EJR request, refer to Rule 44.6 for special instructions on deadlines for jurisdictional challenges and provider responses thereto.

44.4.3 Provider Responses

Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

COMMENTARY:

In most instances, the reasons for a jurisdiction challenge are apparent early in the case and early resolution preserves resources of all the parties and the Board. The Board rules establish the expectation that Medicare contractors review and notify the Board of jurisdiction questions at least by the date of filing the first response to the appeal. The Board will generally not reschedule a hearing for a late-filed jurisdictional challenge but will hear the arguments on jurisdiction at the hearing.

44.5 Substantive Claim Challenge Filed Pursuant to 42 C.F.R. § 405.1873(a)

Effective for cost reporting periods beginning on or after January 1, 2016, 42 C.F.R. § 413.24(j) (as restated at 42 C.F.R. § 405.1873(a)) includes a "[s]ubstantive reimbursement requirement of an appropriate cost report claim." Specifically, § 413.24(j)(1) states that, "[i]n order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, *the provider's cost report*, whether determined on an as-submitted, as-amended, or as-adjusted basis . . ., must include an appropriate claim for the specific item . . . ." (Emphasis added.) If any party to an appeal before the Board questions whether *the provider's cost report at issue in an appeal* complied with this regulatory requirement (*i.e*., questions whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed), then that party must follow the applicable process described below to file this "Substantive Claim Challenge" in order to initiate Board review of such question(s) under 42 C.F.R. § 405.1873(b).

NOTE: The Board adoption of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether *the cost report at issue* included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items.

44.5.1 Individual Cases

A party that questions whether *the cost report at issue* included an appropriate reimbursement claim for one or more issues being appealed must file a Substantive Claim Challenge no later than the filing deadline for the Medicare contractor's preliminary position paper, unless the moving party's filing demonstrates good cause. The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* Rule 44.2 for sample language. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).

- *Expedited Challenge Filing Deadline When an EJR Request Is Filed Per Board Rule 42*.---If the provider files an EJR request prior to the Medicare contractor filing its preliminary position paper, then any Substantive Claim Challenge *on the issue that is the subject of the EJR request* must be filed within five (5) business days of

the EJR request (to the extent it has not already been filed or unless the moving party demonstrates good cause). In this situation (and consistent with 42 C.F.R. §§ 405.1842(e)(3), (3)(ii) and 405.1873(b)(1), (d)(2) and Board Rule 42.1), the Board will then issue a Scheduling Order setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request.

Following the completion of the parties' briefing, the Board will rule on the Substantive Claim Challenge based on the record ***unless*** a party requests otherwise by motion (*e.g*., request for additional time to submit evidence, request a hearing to present argument and evidence) ***and*** the Board grants leave for any additional filings or proceedings.

44.5.2 Group Cases (CIRP and Optional)

A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause. The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).

- *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42*.--- If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.

Following the completion of the parties' briefing, the Board will issue its findings and legal conclusions on the Substantive Claim Challenge based on the record ***unless*** a party requests otherwise by motion (*e.g*., requests additional time to submit evidence, requests a hearing to present argument and evidence) ***and*** the Board grants leave for additional filings and/or proceedings.

44.6 Special Rules for Filing Challenges (Jurisdictional or Substantive Claim) in Group Cases When an EJR Request is Filed within 60 Days of the Final Schedule of Providers

If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either:

1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or

2. Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).

If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJR request***. Following receipt of those challenges (and consistent with 42 C.F.R. §§ 405.1842(e)(3), 405.1873(b)(1), and 405.1873(d)(2) and Board Rule 42.1), the Board will issue a Scheduling Order setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request. NOTE: If the Medicare contractor files the certification, then the failure of the Medicare contractor to file any challenges within the 20-day deadline will be grounds for the Board to take remedial action pursuant to 42 C.F.R. § 405.1868(c)(1), unless the Medicare contractor establishes good cause.

Rule 45 Recusal of Board Members

45.1 General/On Own Motion

A Board member may recuse him or herself if there are reasons that might give the appearance of an inability to render a fair and impartial decision. The parties will be notified of such recusals and the record will reflect the recusals.

45.2 Party May Request Recusal

A party may also request a recusal prior to the hearing date. The written request must be filed with the Board member with a copy to the opposing party. If the Board member does not agree to the recusal, the party may petition the entire Board, in writing, for reconsideration. The Board member whose recusal is sought will not participate in the reconsideration.

45.3 Recused Board Members

A Board member who is recused does not engage in any discussions on the matters under consideration.

Rule 46 Withdrawal of an Appeal or Issue within an Appeal

If a provider desires to withdraw a case or issue(s), the provider must file a request to withdraw the issue(s) or case (*see* Rule 2). Further, it is the provider's responsibility to promptly file requests to withdraw in the following situations:

- An issue(s) or case that the provider no longer intends to pursue;
- An issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution;
- An issue(s) for which the Medicare contractor has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Medicare contractor where the Medicare contractor agreed to that reopening;
- All issues in a case where the provider intends to pursue reopening simultaneously with the appeal request (*see* Rule 47.2.3); and
- A case in which all issues have been handled, whether by administrative resolution, transfer, dismissal, or withdrawal.

When a provider notifies the Board that it is withdrawing an issue(s), the provider's notification must:

1. Describe the specific issue(s) being withdrawn;
2. Address whether the withdrawal is conditioned/dependent on the Medicare contractor's action through an administrative resolution or reopening; and
3. Confirm whether there are any other issues remaining in the case and, if so, provide the status on each remaining issue.

NOTE: A provider's request for withdrawal is self-effectuating and does *not* require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does ***not*** issue a similar notice when the withdrawal does not result in the closure of the case.

Rule 47 Reinstatement

47.1 Motion for Reinstatement

A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing

motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.

47.2 Reinstatement Requests Subsequent to Withdrawal

47.2.1 Administrative Resolution

Upon written motion, the Board will grant reinstatement of an issue(s)/case if an issue(s)/case was withdrawn as a result of an administrative resolution in which the Medicare contractor agreed to reopen a final determination under appeal with the Board but failed to issue a new final determination (*e.g.*, Revised NPR) for that issue(s) as agreed. In its motion for reinstatement, the provider must attach a copy of the relevant administrative resolution.

47.2.2 Medicare Contractor Agreement to Reopen

Upon written motion, the Board will grant reinstatement of an issue(s)/case if a provider requested to withdraw an issue(s) from its case because the Medicare contractor agreed to reopen/revise the cost report for that issue(s) but failed to reopen the cost report and issue a new final determination (*e.g.*, Revised NPR) for that issue(s) as agreed. In its motion for reinstatement, the provider must attach a copy of its reopening request and the correspondence from the Medicare contractor where the Medicare contractor agreed to reopen the final determination for that issue(s).

47.2.3 Requests to Pursue Reopening Simultaneous to Appeal Filing

Upon written motion, the Board will grant reinstatement of an issue(s) in an appeal if a provider requested to withdraw the issue(s) from its case and the case in its entirety simultaneously with filing the appeal to resolve the issue(s) through a reopening and the Medicare contractor either issues a reopening denial or fails to reopen the cost report and issue a new final determination (*e.g.*, Revised NPR) for that issue(s). This action would occur by the provider filing a jurisdictionally and procedurally valid appeal with the Board to preserve its appeal rights, then simultaneously withdrawing all issues to pursue resolution of those issues with its Medicare contractor through a reopening.

This Rule only applies to new appeals filed, where all the issue(s) filed (and not immediately transferred to group appeals) can be resolved through a reopening, and the provider simultaneously withdraws the entire appeal to pursue reopening. In this situation, the provider does not have to obtain the Medicare contractor's agreement to reopen prior to the withdrawal of the appeal (unlike Rule 47.2.2). However, if the entire appeal cannot be withdrawn or if the withdrawal is not submitted simultaneous to the appeal filing, then this rule does not apply to the appeal, and the provider must get the Medicare contractor's approval for reopening pursuant to Rule 47.2.2 for that issue(s) to be withdrawn.

In its motion for reinstatement, the provider must attach a copy of its reopening request and the correspondence from the Medicare contractor where the Medicare contractor denies the reopening.

47.3 Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.

Rule 48 Subpoenas

48.1 Only the Board Can Issue a Subpoena

The regulations regarding issuance of subpoenas for either discovery or a hearing are found at 42 C.F.R. § 405.1857. The request for a subpoena must:

- Be filed with the Board according to Rule 2 except that if the filing is exempt from mandatory electronic filing then the request for a subpoena must filed via overnight mail or delivery service;
- Have the outside of the envelope marked “SUBPOENA REQUEST”;
- Be sent to the following, as relevant, via overnight mail with the outside of the envelope marked “SUBPOENA REQUEST”:
  - the individual to be subpoenaed (or the custodian of records being subpoenaed), and
  - any party to the appeal who is exempt from filing electronically;
- State if the individual is requested to appear in person or by telephone; and, if a telephone appearance is not satisfactory, explain why;
- If the subpoenaed individual is a non-party, include a notice that the individual may respond to the Board in writing (using the Board’s address in Rule 3.2) either upon notice of the request or upon issuance of the subpoena, if the Board approves the request; and
- Must include the contact information (name and address) of the person to be subpoenaed or the location of the documents to be obtained along with the contact information for the custodian of the documents.

If the Board grants the request for subpoena, then the Board will handle the service of the subpoena.

48.2 Response

The party or nonparty has 15 days from the date the subpoena request was received to respond to the subpoena request. Responses by parties must be filed according to Rule 2. Responses by nonparties must be filed according to Rule 3.2 and, following receipt, the Board will upload the nonparty's response into OH CDMS and issue the parties a copy.

Rule 49 Intentionally Left Blank

Rule 50 Special Rules for Children's Hospital Graduate Medical Education ("CHGME") Appeals

50.1 General

CHGME is funded through an appropriation to the Department of Health & Human Services, the Health Resources & Services Administration ("HRSA"), and the Bureau of Health Profession.

Children's hospitals that operate graduate medical education programs are entitled to payments for direct and indirect expenses associated with operating those programs. The Secretary determines any changes in the number of residents reported by a hospital to determine the final amount payable. The final amount determined is considered a final determination that can be appealed to the Provider Reimbursement Review Board under 42 U.S.C. § 1395oo. *See* 42 U.S.C. § 256e.

Payments to children's hospitals are based on the hospital's share of the total amount of direct and indirect Medicare education funding available in any federal fiscal year ("FFY"). This funding is part of a fixed payment pool that is distributed prior to the close of each FFY. As a result, these appeals before the Board must be heard on an accelerated schedule so that the providers' reimbursement is accurately determined prior to the end of the FFY.

50.2 Process for Filing a CHGME Appeal

50.2.1 Time for Filing

The regulations provide a 180-day appeal period for any final determination. However, children's hospital providers which delay filing run the risk of not being able to have a hearing and receive a written decision before the end of the applicable FFY.

50.2.2 Where to File

Effective November 1, 2021, appeals must be filed electronically through OH CDMS unless an exemption under Rule 2.1.1 applies. *See* Rule 2 addressing electronic filing and https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

If an exemption under 2.1.2 applies, you may file in hard copy using the following address:

Provider Reimbursement Review Board
CMS Office of Hearings
ATTN: PRIORITY CHGME APPEAL
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850

50.2.3 Telephone Notice to Board

Please call the Division of Systems and Case Management at (410) 786-2671 and indicate the date and method of delivery for submitting the provider's request.

50.2.4 No Supporting Documentation to Board with Initial Filing

See Rule 50.3 on documentary evidence to file with the Board. DO NOT send additional supporting documentation to the Board with the initial CHGME hearing request.

50.2.5 Other Parties to Receive Notice of Appeal and Supporting Documents

The Office of General Counsel ("OGC") represents the Agency in CHGME cases before the Board. Accordingly, a copy of the hearing request ***and all documents that support the provider's claim*** for reimbursement must be sent electronically to: PHandSBRANCHCONTROLS@hhs.gov. Include "PRIORITY CHGME APPEAL" in the subject line of the email.

50.3 Filing CHGME Appeal: Content and Format

The appeal to the Board must contain the information and documents listed below.

A. Contact Information

1. Provider information including provider name, number, and complete address
2. Medicare Administrative Contractor
3. Designated representative information to identify who will represent the provider (whether internal or external) including a letter of representation (see Rule 5)

B. Final Determination Information

1. Fiscal year end of the cost report from which the FTE count was reviewed

2. A copy of the “CHGME Program Payment Assessment of Full-Time Equivalent Resident Count”

C. Issue Information (*see* Rules 7 and 8)

1. Issue title(s) and a complete statement of the issue(s) under appeal
2. For each issue, identify the relevant audit adjustments and include a copy of the associated audit adjustment report pages
3. For each issue, identify the amount in controversy and provide a calculation of the amount in controversy with supporting documentation.

50.4 Board Acknowledgement of Filing CHGME Appeal

The Board will notify the provider of position paper due dates and the date of hearing after receipt of the hearing request. Supporting documentation is to be submitted with the provider’s position paper. The position paper should include appropriate references to the exhibit numbers and pages that support the position. All personal identifying information, such as social security numbers, must be redacted from hearing requests, position papers, and exhibits.

50.5 Position Papers

The provider may have as little as one week to file position papers, depending on the date of the filing and the Board’s hearing schedule. Position papers must conform to Rule 25.

50.6 Public Health Service Response to CHGME Appeal

The response to the CHGME appeal is to conform to the rules outlined in this document. The Board will set the time for response in the Acknowledgement.

50.7 Extensions/Postponements

The Board disfavors requests for extensions of time for filing or postponements of CHGME hearings because of the need to conduct hearings and render decisions in a short period of time. Any request for an extension must be in writing and will be considered when extraordinary circumstances exist. An extension will generally not be granted on the grounds that the parties are conducting negotiations.

APPENDICES

Appendix A:
Model Form A – Individual Appeal Request or Supplemental Appeal from Additional Final Determination

All appeal requests and subsequent correspondence must be filed through OH CDMS unless an exemption under Rule 2.1.2 applies. *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

Select the type of appeal request.

☐ **Initial Individual Appeal Request**

Electronic form is accessible from the PRRB Home page in OH CDMS.

or

☐ **Supplemental Appeal from Additional Final Determination**

Electronic form is accessible from the Case Correspondence drop-down on the Case Actions page in OH CDMS.

If additional final determination, identify the case number of the individual appeal to which this request is being added: _____

General Information

Provider Information

Provider Number: _____

Provider Name: _____

Street Address: _____

City, State and ZIP: _____

Parent Information

Is this Provider associated with a Parent for the year under appeal? ☒ Yes ☐ No

If yes:

Parent Organization: _____

Street Address: _____

City, State and ZIP: _____

MAC Information

MAC Code: _____

MAC Name: _____

For additional information regarding the MACs, please see Medicare Administrative Contractors from CMS.gov.

Representative Information

Name: _____

Title: _____

Organization: _____

Address: _____

City, State and ZIP: _____

Telephone Number: _____

E-mail Address: _____

Attach Representation Letter.

Determination Information

Select the type of final determination being appealed.

☐ **Notice of Program Reimbursement**

☐ **Revised NPR**

☐ **Exception Determination**

☐ **Federal Register Notice**

☐ **Failure to Issue a Timely Determination**

☐ **Quality Reporting Payment Reduction**

☐ **Other**

Enter the determination details and provide support as noted in the respective Determination Support section.

Determination Support:
Notice of Program Reimbursement

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Revised NPR

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Attach the Reopening Request that preceded the Revised NPR (if applicable).

Attach the Reopening Notice issued by the MAC.

Prior NPR Issuance Dates:

Enter the issuance dates for the original NPR and any revised NPRs issued prior to the determination under appeal**.**

_____ _____ _____ _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Exception Determination

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Exception: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Federal Register Notice

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Federal Register Citation: _____

Determination Support:
Failure to Issue a Timely Determination

Fiscal Year End Date: _____

MAC Receipt Date of Filed Cost Report: _____

Attach evidence of the MAC's receipt date for the filed or amended cost report.

Attach evidence of the MAC's acceptance or rejection of that cost report

Determination Support:
Quality Reporting Payment Reduction

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Quality Reporting Program: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Other

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Other Final Determination: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Appeal Issues

Complete this page for each issue being appealed.

Issue-Related Information

Issue Number: _____

Issue Title: _____

Attach Issue Statement.

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

Optional: Attach other issue-related documents not identified above that are necessary to support jurisdiction in this case.

Certifications

Check each box to accept the following certification statements.

☐ I certify that none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☐ I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).

☐ I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.

☐ I certify that I am authorized to submit an appeal on behalf of the listed provider.

Signature: _____

Printed Name: _____

Date: _____

Appendix B:
Model Form B – Group Appeal Request

All appeal requests and subsequent correspondence must be filed through OH CDMS unless an exemption under Rule 2.1.2 applies. *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

General Information

Select the type of group.

☐ **Optional Group**

☐ **Common Issue Related Party ("CIRP") Group**

Electronic forms for both group types are accessible from the PRRB Home page in OH CDMS.

Parent Information

(Applicable to CIRP groups only)

Parent Organization: _____

Street Address: _____

City, State and ZIP: _____

Representative Information

Name: _____

Title: _____

Organization: _____

Address: _____

City, State and ZIP: _____

Telephone Number: _____

E-mail Address: _____

Issue Information

Issue Title: _____

Attach Issue Statement.

Is this appeal based on a Federal Register Notice? _____

If yes, enter **Federal Fiscal Year:** _____

If no, enter **Calendar Year:** _____

Lead MAC Information

MAC Code: _____

MAC Name: _____

For additional information regarding the MACs, please see Medicare Administrative Contractors from CMS.gov. For information regarding Lead MAC selection, *see* Rule 19.

Group Participants

For each participant being transferred into this group, complete a transfer request (see Model Form D).

For each participant being directly added into this group from its final determination, complete a direct add request (see Model Form E).

Attach Representation Letters for each provider.

Certifications

Check each box to accept the following certification statements.

☐ I certify that the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☐ APPLICABLE TO OPTIONAL GROUPS ONLY
I certify to the best of my knowledge that there are no other providers to which these participating providers are related by common ownership or control that have a pending request for a Board hearing on the same issue for a cost reporting period that ends in the same calendar year covered in this request. *See* 42 C.F.R. § 405.1837(b)(1)(i).

☐ I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.

☐ I certify that I am authorized to submit an appeal on behalf of the listed providers.

Signature: _____

Printed Name: _____

Date: _____

Appendix C:
Model Form C – Request to Add Issue

All appeal requests and subsequent correspondence must be filed through OH CDMS unless an exemption under Rule 2.1.2 applies. *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

Electronic form is accessible from the Case Issues page of OH CDMS if the period to add issues has not yet expired.

Case Number: _____

Case Name: _____

Issue-Related Information

Final Determination Type: _____

Date of Final Determination under Appeal: _____

Issue Title: _____

Attach Issue Statement.

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

Optional: Attach other issue-related documents not identified above that are necessary to support jurisdiction in this case.

Certifications

Check each box to accept the following certification statements.

☐ I certify that this issue is not pending in any other appeal for the same period and provider, and has not been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☐ I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on this issue for a cost reporting period that ends in the same calendar year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).

☐ I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.

☐ I certify that I am authorized to submit an appeal of this issue on behalf of the listed provider.

Signature: _____

Printed Name: _____

Date: _____

Appendix D:
Model Form D – Request to Transfer Issue

All appeal requests and subsequent correspondence must be filed through OH CDMS unless an exemption under Rule 2.1.2 applies. *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

Electronic form is accessible from the Case Issues page of OH CDMS if the referenced issue is still in an open status.

Individual Case Number: _____

Individual Case Name: _____

Transfer Information

Group Case Number: _____

Group Case Name: _____

Attach Representation Letter for group appeal.

If filing the transfer through OH CDMS, you may stop here.
If filing the transfer request in ***hard copy***, also answer the following determination and issue-related questions and attach a complete copy of the initial appeal request.

Determination Information

Final Determination Type: _____

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

MAC Code: _____

MAC Name: _____

Issue-Related Information

Issue Title: _____

Was this issue protested on the filed cost report? _____

Audit Adjustment Number: _____

Amount in Controversy: _____

Certifications

Check each box to accept the following certification statements.

☐ I certify that this issue is not pending in any other appeal for the same period and provider, and has not been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☐ I certify that I have reviewed the regulations at 42 C.F.R. § 405.1837, the Board Rules and consulted with the Representative of the group case to which this issue is being transferred. I have a good faith belief that this transfer request meets the single common issue requirement for a group appeal.

☐ APPLICABLE TO OPTIONAL GROUPS ONLY
I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on this issue for a cost reporting period that ends in the same calendar year covered in this request. See 42 C.F.R. § 405.1835(b)(4)(i).

☐ I certify that I am authorized to submit this transfer on behalf of the listed provider.

Signature: _____

Printed Name: _____

Date: _____

Appendix E:
Model Form E – Request to Directly Add Provider to Group

All appeal requests and subsequent correspondence must be filed through OH CDMS unless an exemption under Rule 2.1.2 applies. *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

Electronic form is accessible from the Case Correspondence drop-down on the Case Actions page in OH CDMS.

Group Case Number: _____

Group Case Name: _____

General Information

Provider Information

Provider Number: _____

Provider Name: _____

Street Address: _____

City, State and ZIP: _____

MAC Information

For direct add requests in OH CDMS, this information will be collected on the Determination Support page.

MAC Code: _____

MAC Name: _____

For additional information regarding the MACs, please see Medicare Administrative Contractors from CMS.gov.

Representative Information

For direct add requests in OH CDMS, this information will be collected on the Issue-Related Information page.

Attach Representation Letter for participation in group appeal.

Issue-Related Information

Issue Title: _____

Note: The identification of the issue title is for reference only. The provider will adopt the issue title and issue statement of the group case.

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

Optional: Attach other issue-related documents not identified above that are necessary to support jurisdiction in this case.

Determination Information

Select the type of final determination being appealed.

☐ **Notice of Program Reimbursement**

☐ **Revised NPR**

☐ **Exception Determination**

☐ **Federal Register Notice**

☐ **Failure to Issue a Timely Determination**

☐ **Quality Reporting Payment Reduction**

☐ **Other**

Enter the determination details and provide support as noted in the respective Determination Support section.

Determination Support:
Notice of Program Reimbursement

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Revised NPR

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Attach the Reopening Request that preceded the Revised NPR (if applicable).

Attach the Reopening Notice issued by the MAC.

Prior NPR Issuance Dates:

Enter the issuance dates for the original NPR and any revised NPRs issued prior to the determination under appeal**.**

_____ _____ _____ _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Exception Determination

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Exception: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Federal Register Notice

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Federal Register Citation: _____

Determination Support:
Failure to Issue a Timely Determination

Fiscal Year End Date: _____

MAC Receipt Date of Filed Cost Report: _____

Attach evidence of the MAC's receipt date for the filed or amended cost report.

Attach evidence of the MAC's acceptance or rejection of that cost report

Determination Support:
Quality Reporting Payment Reduction

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Quality Reporting Program: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Determination Support:
Other

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Other Final Determination: _____

Was the final determination received more than 5 days after issuance? _____

If yes, **Actual Date the Final Determination Was Received:** _____

Attach Proof of Receipt.

Certifications

Check each box to accept the following certification statements.

☐ I certify that none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

☐ I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).

☐ I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.

☐ I certify that I am authorized to submit an appeal on behalf of the listed provider.

Signature: _____

Printed Name: _____

Date: _____

Appendix F:
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For information regarding Proposed Joint Scheduling Orders, *see* Rules 23 and 24.

Appendix G:
Model Form G – Schedule of Providers

Case Number: _____ **Page:** _____ of _____

Group Case Name: _____ **Date Prepared:** _____

Group Representative: _____

Lead MAC Name/Code: _____

Issue Title: _____

					A	B	C	D	E	F	G
#	Provider Number	Provider Name/ Provider Location (City, State)	Appealed Period (and impacted CRPs)	MAC Name/ MAC Code	Date of Final Determination	Date of Appeal Request/ Add Issue	Number of Days	Audit Adjustment Number	Amount in Controversy	Prior Case Number(s)	Date of Direct Add or Transfer

Appendix H: Acronyms

Acronym	Term
CHGME	Children's Hospital Graduate Medical Education
CIRP	Common Issue – Related Party
CMS	Centers for Medicare & Medicaid Services
CRPs	Cost Reporting Periods
DSH	Disproportionate Share Hospital
EJR	Expedited Judicial Review
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources & Services Administration
IPPS	Inpatient Prospective Payment System
NPR	Notice of Program Reimbursement
OAA	Office of the Attorney Advisor for the CMS Administrator
OGC	Office of General Counsel
OH	Office of Hearings
OH CDMS	Office of Hearings Case and Document Management System
PHI	Protected Health Information
PII	Personally Identifiable Information
PJSO	Proposed Joint Scheduling Order
PRRB	Provider Reimbursement Review Board

Table 1: Acronyms

Appendix I: Record of Changes

These rules apply to appeals pending as of, or filed on or after the effective date of the rules. These rules supersede the Board's previous rules and instructions and the Board may revise these rules to reflect changes in the law, regulations or the Board's policy and procedures.

Version Number	Effective Date	Description of Change
1.0	08/21/2008	Issued Rules in conjunction with new appeal regulations for Medicare Part A Provider Reimbursement Determinations and Appeals. These regulations at 42 C.F.R. § 405, Subpart R, affected all PRRB appeals pending as of, or filed on or after the effective date of the rules. *See* Fed. Reg. 30190 (May 23, 2008).
1.1	07/01/2009	Revised Rules 3, 4, 24 and 41; updated content of proposed joint scheduling order (Model Form F); and modified model forms to fillable pdf format. *See* PRRB Alert 5.
1.2	03/01/2013	Revised Rules 3, 4, 5, 7, 9, 11, 12, 14, 15, 16, 20, 21, 22, 24, 27, 30, 37, and 44; and updated model forms to incorporate changes to the Rules. *See* PRRB Alert 9.
1.3	07/01/2015	Revised Rules 46 and 48 regarding reinstatements and withdrawals at. *See* PRRB Alert 11.
2.0	08/29/2018	Revised Rules to address changes in the Board's policies and procedures and for the implementation of the Board's electronic filing system (OH CDMS). *See* PRRB Alerts 14 and 15.
3.0	11/01/2021 Superseded before becoming effective	Revised Rules to implement mandatory electronic filing consistent with the FY 2021 IPPS Final Rule and includes other changes and clarifications such as updating the case representatives' responsibilities, allowing Board Orders as extension of Board Rules, requiring certain information on parent owners, updating Board Rules on substantive claim challenges, and adding video hearings as an alternative hearing forum. *See* Board Alert 21.

Version Number	Effective Date	Description of Change
3.1	11/01/2021	Supersedes and replaces Version 3.0 and either corrects certain identified errors or clarifies the revisions to the Board Rules published on June 16, 2021. *See* Board Alert 22.
3.2	12/15/2023	Updated all CMS.gov hyperlinks.

Table 2: Record of Changes