PROVIDER REIMBURSEMENT REVIEW BOARD RULES

The Provider Reimbursement Review Board's (Board) Rules, which are effective July 1, 2015, are attached. These rules apply to appeals pending as of, or filed on or after, July 1, 2015. The changes to the previous version of the PRRB Rules dated March 1, 2013, have been highlighted and dated with the effective date of the changes.

These Rules supersede the Board's previous Instructions. The Board may revise these Rules to reflect changes in the law, regulations or the Board's policy and procedures.

[Issued Aug. 21, 2008; Revised July 1, 2009; March 1, 2013; July 1, 2015]

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PART I:
FILING APPEALS AND INTERMEDIARY (MEDICARE ADMINISTRATIVE CONTRACTOR/INTERMEDIARY) RESPONSE

Rule 1 – Overview

1.1 – Authority

These Rules govern proceedings before the Provider Reimbursement Review Board ("PRRB" or "Board"). The Rules are consistent with Section 1878 of the Social Security Act, 42 U.S.C. § 1395oo and 42 C.F.R. §§ 405.1835 – 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. While these instructions 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.

1.2 – Model Forms

To assure your appeal filing is complete and to assist the Board with a very large case load, please use the model forms A-F in the appendix.

1.3 – References to Intermediary Includes Medicare Administrative Contractor

1.4 – 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).

Rule 2 – Good Faith Expectations

In accordance with the regulations, the Board expects the parties to communicate early, act in good faith and attempt to negotiate areas of misunderstanding and differences.

Rule 3 – Correspondence Requirements

3.1 – PRRB Mailing Address

All documents must be addressed as follows:

Provider Reimbursement Review Board
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670

3.2 – Delivery of Materials to the Board

Documents may be submitted to the Board in any one of the following ways:

- By regular mail (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, UPS, DHL, etc.)
- By hand or courier

Be sure to allow sufficient time for documents to be received in a timely manner. The normal business hours for the mail room are 8:00 am to 4:00 pm, Monday thru Friday. *[July 1, 2009*]
Hand deliveries must be made to the mail room during normal business hours. The Board suggests that you call ahead to inform of the delivery so that someone will be available to accept delivery or sign for it. *[March 2013]*

3.3 – 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. *[March 2013]*

3.4 – No Multiple Copies to Board and Staff

Unless requested otherwise, do not file multiple copies of submissions to Board members and staff. Do not address documents to individual staff or Board members unless instructed to do so.

3.5 – Caption and Case Number on All Submissions

All filings and correspondence must contain the case number (except for the initial hearing request) the Provider or group name, the provider number (for individual appeals), and the fiscal year end (or calendar year end at issue for groups).

3.6 – Submissions of Materials Involving Multiple Case Numbers

If a submission applies to multiple cases, the Board requires that copies be sent for each case referenced in the document, with each respective case number highlighted. *[March 2013*]

Rule 4 – Board Jurisdiction/Appealing Issues

4.1 – General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

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 – Date of Receipt Presumption/Calculating Filing Deadlines

The date of receipt of a final determination is presumed to be 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 date of receipt of documents is presumed to be the date:

- stamped "received" by the Board on documents submitted by regular mail, hand or non-nationally recognized next-day courier.
- of delivery to the Board on documents transmitted by a nationally-recognized next-day courier as evidenced by the courier's tracking bill. It is the responsibility of the Provider to maintain record of delivery. *[July 1, 2009]*

See 42 C.F.R. § 405.1801(a)(2).

CAUTION: This is a change from the prior regulation and Board practice.

4.4 – Dismissal for Lack of Jurisdiction

Appeals that fail to meet the jurisdictional requirements will be dismissed. A jurisdictional challenge 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.

4.5 – No Duplicate Filings

A Provider may not appeal an issue from a final determination in more than one appeal.

4.6 – Issue Location

A. General Rule

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

B. Exceptions - Board Order Establishes Location

1. Requests to Join Fully Formed Groups: 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.)

2. Transfer Requests from Group Cases into Other Appeals: Once a Provider has joined a group, a transfer will be permitted only on written motion approved by the Board. (*See* Rule 17.) *[March 2013]*

4.7 – Dismissed or Withdrawn Issues

Once an issue is dismissed or withdrawn, the issue may not be appealed in another case.

Rule 5 – Provider Case Representative

5.1 – Persons

The case representative is the individual with whom the Board maintains contact. A case representative may include a "designated" case representative (e.g., attorney or consultant), or an employee (non-owner or non-officer). If no case representative is designated, the Board will consider the owner or officer who filed the appeal as the case representative. There may be only one case representative per appeal.

The contact information for the case representative that is on file with the Board must be current with the Board at all times. As the Board sends much of its correspondence electronically, maintaining a current e-mail address on file with the Board is a responsibility of the case representative (*see* Rule 5.2) and is imperative to ensure that the case representative receives Board correspondence. *[March 2013]*

5.2 – Responsibilities

The representative is responsible for informing the Board of changes in his or her contact information, for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party. <u>All actions by the representative are considered to be those of the Provider</u> (But see Model Form D certification that Provider has been notified on transferring an issue to a group appeal). Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.

5.3 – Communications with Providers

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

5.4 – Designation of Representative Letter

The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. The letter must reflect the Provider's fiscal year under appeal and must also contain the following contact information: name, organization, address, telephone number, fax number and e-mail address of the representative. *[March 2013]*

5.5 – Withdrawal of Representation

A. Deadlines Must Continue to be Met

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

B. Provider's Consent Obtained

A designated representative may withdraw an appearance by filing a notice of withdrawal signed by such representative and the owner or officer of the Provider. Such notice should also contain a statement regarding who will represent the Provider, his/her contact information, and contain an attached Authorization of Representation.

C. Provider's Consent Not Obtained

If a Provider's written consent is not obtained, the representative must file a withdrawal notice listing the Provider's last known contact information (contact person, address, telephone number, e-mail address). The representative must send a copy of the withdrawal notice to the Provider.

Rule 6 – Filing an Individual Appeal (Appendix - Model Form A)

6.1 – General - Content and Supporting Documentation

To file an individual appeal (1) complete Model Form A – Individual Appeal Request – Initial Filing and (2) include all supporting documentation listed on the request.

6.2 – Cost Reporting Period/Multiple Final Determinations Involving the Same Cost Reporting Period

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.), separate appeal requests must be timely filed for each subsequent final determination. When filing a subsequent appeal request for the same cost reporting period, identify the case number of the existing individual appeal.

As a general rule, the Board will consolidate all appeals from final determinations for the same cost reporting period into the existing case number. The Board expects the parties to meet deadlines in the existing case for both the old and new issues although the Board will consider motions to extend such deadlines for newly added issues from subsequent determinations. The Board, upon its own motion, or upon motion of the parties, may issue separate case numbers for the new issues.

6.3 – Amount in Controversy Calculations/Support (42 C.F.R. §§ 405.1835 and 405.1839)

An individual appeal request must have a total amount in controversy of at least $10,000. For each issue, provide a calculation or support demonstrating the amount in controversy.

6.4 – Certifications

An authorized representative of the Provider must sign the appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider.

Rule 7 – Issue Statement and Claim of Dissatisfaction

For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See* Rule 8 for special instructions regarding multi-component disputes.)

7.1 – NPR or Revised NPR Adjustments

A. Identification of Issue

Give a concise issue statement describing:
- the adjustment, including the adjustment number,
- why the adjustment is incorrect, and
- how the payment should be determined differently.

NOTE: If you are appealing from a **Revised NPR**, you **MUST** submit a copy of:

- the NPR that is immediately preceding the Revised NPR under appeal,
- the Revised NPR,
- the Reopening Request that preceded the Revised NPR (if applicable),
- the Reopening Notice issued by the Intermediary,
- the Revised NPR workpapers (for the issue(s) under appeal), and
- any applicable cost report worksheets (e.g., Worksheet E).

The Board requires this information for determining whether the jurisdictional and filing requirements for an appeal involving a Revised NPR have been met. *[March 2013]*

B. No Access to Data

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.

7.2 – Self-Disallowed Items

A. 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 issue statement describing the self-disallowed item
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed. *[March 2013]*

B. 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.

C. Protest

Effective for cost reporting periods ending on or after December 31, 2008, items not being claimed under subsection A above must be adjusted through the protested cost report process. The Provider must follow the applicable procedures for filing a cost report under protest as contained in CMS Pub. 15-2, Section 115. *See* 42 C.F.R. § 405.1835(a)(1)(ii). *[March 2013]*

CAUTION: The regulations require specific steps on filing the cost report to preserve a right to appeal self-disallowed items.

7.3 – Other Final Determinations (e.g., wage index determinations)

If you are appealing from a final determination other than a cost report adjustment, provide:

- the date of the determination,
- the controlling authority in dispute,
- the authority granting the Board's jurisdiction over the dispute, and
- an explanation regarding why the Intermediary or CMS determination was improper.

7.4 – Failure to Timely Issue Final Determination

If your appeal is based on the failure of the Intermediary to timely issue a final determination, provide a copy of:

- the certification page of the perfected or amended cost report,
- the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports,
- the Intermediary's letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and
- the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items *[March 2013]*

Rule 8 – Framing Issues for Adjustments Involving Multiple Components

8.1 – General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.

8.2 – Disproportionate Share Cases
(e.g., dual eligible, general assistance, charity care, HMO days, etc.)

8.3 – Bad Debts Cases
(e.g., crossover, use of collection agency, 120-day presumption, indigence determination, etc.)

8.4 – Graduate Medical Education/Indirect Medical Education
(e.g., managed care days, resident count, outside entity rotations, etc.)

8.5 – Wage Index
(e.g., wage vs. wage-related, rural floor, data corrections, etc.)

Rule 9 – Board Acknowledgement of Appeals & Written Communications with the Board

The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

The acknowledgment and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines (including deadlines established by a JSO, *See* Rule 23.2) may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

NOTE: The Board began sending electronically the Acknowledgement and Critical Due Dates Letters in May 2008, along with Notices of Hearing in July 2009. As a result, the case representative can expect to receive such notices in this manner at the e-mail address on file with the Board. If the Provider has not received an acknowledgement letter from the Board establishing critical due dates within 30 days following the filing of an appeal request, the case representative should contact the Board at 410-786-2671. Per Rule 41.2, the Board may dismiss a case for failure to comply with any of the critical due dates and, therefore, it is imperative that the Provider maintain current contact information on file with the Board (including e-mail address) per Rule 5.2.) *[March 2013]*

Rule 10 – Intermediary Response upon Filing of Individual Appeal (42 C.F.R. § 405.1853)

10.1 – Duty to Confer

Once the deadline for the Provider to add issues has passed, it is the Intermediary's responsibility to:

- promptly review the Provider's appeal as provided in the regulations,
- advise the Board, in writing, as to any challenges to Board jurisdiction, including identification of the issue(s) challenged, the basis for the challenge and any supporting documentation, and
- confer with the Provider regarding stipulations. If the Provider has filed a motion for good cause extension of time for requesting a Board hearing, the Intermediary may wait to confer regarding stipulations until the Board adjudicates the motion. (*See* 42 C.F.R. § 405.1836.)

10.2 – Duty to Respond to Requests

If the Intermediary opposes a Provider's Expedited Judicial Review (EJR) request, motion for good cause extension of time limit 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 – Adding a New Issue to an Individual Case (Appendix - Model Form C)

11.1 – General - Request and Documentation

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

- timely files a request to the Board to add issues no later than 60 days after the expiration of the applicable 180 days period for filing the hearing request (*see* Appendix – Model Form C), **AND**
- includes all of supporting documentation listed on Model Form C. *[March 2013]*

11.2 – 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.

11.3 – No Board Acknowledgement of Added Issue

The Board will not acknowledge the addition of issues to an existing appeal. It is the Provider's responsibility to maintain evidence of timely filing.

Rule 12 – Filing an Initial Group Appeal (Appendix - Model Forms B and D)

12.1 - General – Form and Documentation

To file a group appeal: (1) complete Model Form B - Request for Group Appeal, and (2) include all supporting documentation listed on the request. If the group is formed by a transfer from an existing individual appeal, complete Model Form D - Transfer and Model Form B (*see* Appendix).

NOTE: Any Provider transferring an issue from an individual appeal to a group must submit for each Provider in the Group Appeal Request **two** copies of Model Form D.

- The first copy of the Model Form D must be included with the Group Appeal Request documents.
- The second copy of the Model Form D is marked "COPY" in the upper right corner. THIS SECOND COPY MUST NOT BE BOUND with any of the Group Appeal Request documents submitted for this initial group appeal request; rather THEY SHOULD BE CLIPPED SEPARATELY and placed behind the Group Appeal Request. *[March 2013]*

12.2 – Group Cost Reporting Periods

Providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, groups may submit a written request to include more than one calendar year to meet the $50,000 amount in controversy.

Commonly owned or controlled Providers with the same issue in cost reporting periods ending in the same calendar year must file a mandatory group appeal if the combined amount in controversy is $50,000 or more. (*See* Rule 12.5 B.)

12.3 – Amount in Controversy Timeframe

The $50,000 threshold must be met by the full formation of the group. (*See* Rule 19.)

12.4 – Authorization for Group Representative (See Rule 5)

A. General Rule

The Board will recognize a single Group Representative for all Providers in the group. The Providers filing the initial appeal must appoint the Group Representative by attaching an Authorization of Representation letter on each Provider's letterhead, signed by an owner or officer of the Provider.

B. Exception for Transfers

If a Provider is joining the group via transfer, an authorization letter is not required. However, the representative of the appeal from which the transfer is made and the Group Representative must complete the certifications on Model Form D (*see* Appendix).

12.5 – Number of Providers in Group

A. Optional Group Appeals

At least two different Providers are required to initially form an optional 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.

B. Mandatory Group Appeals: Common Issue Related Party (CIRP)

Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least $50,000. While one Provider may initiate a CIRP group, at least two different Providers must be in the group upon full formation. (*See* Rule 19.)

12.6 – Optional and Mandatory Group Providers Not Combined

Providers that are not part of a CIRP group may not join a CIRP appeal. Providers that are part of CIRP organizations may not join an optional group 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. However, for judicial economy, separate groups involving the same issue may be heard concurrently.

12.7 – Initial Selection of Lead Intermediary

The Group Representative must designate as the Lead Intermediary the Intermediary that services the majority of Providers listed on the initial appeal request, unless the Group Representative states that he/she has a good faith belief that upon group completion (Rule 19.3), a different Intermediary will ultimately service the greatest number of Providers.

Rule 13 – Common Group Issue

The matter at issue 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(s) may be presented as representative of all group members. Refer to Rules 7 and 8 for guidance.

Rule 14 – Acknowledgment of Group Appeal

The Group Representative and the Lead Intermediary selected by the Group Representative will receive an Acknowledgement via e-mail from the Board indicating that the group appeal has been received and the case number assigned. If the Provider's appeal does not comply with the filing requirements, the

Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to request more information or dismiss the appeal if it is later found to be deficient. *[March 2013]*

The acknowledgment (or future correspondence) may also set various deadlines and due dates including, but not limited to, position paper deadlines, full formation of the group, the Schedule of Providers (s*ee* Appendix - Model Form G), 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 – Intermediary's Responsibilities upon Receipt of Group Appeal

15.1 – Challenging Lead Intermediary Designation on Initial Filing

Within 10 days of receipt of the Board's Acknowledgment of the group, the Intermediary may challenge its designation as the Lead Intermediary pursuant to the Rule 19.4 criteria.

15.2 – Advise Board if Group is Proper

Within 30 days of receipt of the Board's acknowledgment of the group, the designated Lead Intermediary (*see* Rule 12.7) 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 have preserved their right to appeal and meet the jurisdictional and appeal filing requirements except the amount in controversy. *[March 2013]*

15.3 – Duty to Respond to Requests Filed with the Appeal

If the Intermediary opposes the group's Expedited Judicial Review (EJR) request, motions for good cause extension of time for requesting a Board hearing, mediation request, or any other request made with the appeal, its response must be timely filed in accordance with Rules 42, 43, and 44.

Rule 16 – Requests to Join an Existing Group via Transfer from an Individual Appeal or Directly from a Final or Revised Determination (Appendix – Model Forms D and E)

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

16.1 – Filing Requirements

A. Transfers from an Individual Appeal to a Group Appeal

The Provider is required to attach the following supporting documents to its transfer request (Model Form D):

1. a copy of the relevant NPR or Revised NPR;

2. documentation showing that the issue being transferred is currently part of the individual appeal from which it is to be transferred; and

   - If the Provider asserts that the issue was included in the initial appeal request, it MUST attach a copy of the initial appeal request showing that the issue was in fact included in the initial appeal request.

   - If the Provider asserts that the issue was added subsequent to filing the initial appeal request, it MUST attach a copy of the letter and/or a copy of the Model Form C (Request to Add Issue(s) to an Individual Appeal) showing that the issue was in fact added subsequent to filing the initial appeal request.

3. a copy of the documents that are identified in the NOTE at Rule 7.1A if the Provider is appealing from a Revised NPR. *[March 2013]*

B. Requests to Join an Existing Group Directly from a Final Determination

The Provider is required to attach the following supporting documents to its joinder request (Model Form E):

1. a copy of the relevant NPR or Revised NPR; and

2. a copy of the documents that are identified in the NOTE at Rule 7.1A if the Provider is appealing from a Revised NPR. *[March 2013]*

16.2 – No Acknowledgement

The Board will not acknowledge joinder to an existing group appeal. It is the Provider's responsibility to maintain evidence of timely filing. Exception: if the group appeal is fully formed, a joinder request will not add the Provider to the group unless the Board grants written approval. (*See* Rules 4.6.B.1, and 17.3.) *[March 2013]*

Rule 17 – Request to Transfer from Group Appeal into Other Appeals (42 C.F.R. § 405.1837(e)(5)) (Appendix – Model Form D)

The Board will not grant a request to transfer from a group case to another case except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation or common issue requirements. The motion must also include a fully executed Model Form D (Transfer

Form) and Model Form A as appropriate. No transfer from a group to another case is effective unless the transfer request is approved by the Board.

Rule 18 – Restructuring of Groups

After opportunity for comment by the parties, the Board may require a group to restructure appeals to either comply with the law or for judicial economy.

Rule 19 – Completion of Groups (Full Formation) (42 C.F.R. § 405.1837(e))

19.1. – Optional Groups

A. Deadlines

In optional group appeals, the Board will set the deadline to complete the group, generally 12 months from the date of the group hearing request. The Board has the discretion to set a different deadline, or extend such deadline, for case management or administrative efficiency purposes.

B. Closure

The group is fully formed upon the earlier of:

- receipt of a notice from the Group Representative that the group is fully formed,
- the deadline set in the Board's acknowledgment, or
- a Board order that the group is fully formed.

19.2. – Mandatory (CIRP) Groups

Mandatory CIRP group appeals must contain all Providers eligible to join the group which intend to appeal the disputed common issue. The Board will determine that a group appeal is fully formed upon:

- written notice from the Group Representative that the group is fully formed, or
- a Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group.

19.3 – Change of Lead Intermediary upon Full Formation of the Group

A. On Motion of Group Representative

Upon full formation of the group, if the Group Representative believes that the Lead Intermediary should be changed, the Group Representative must contact the current and proposed Lead Intermediary and file within 15 days a motion to change the designation of the Lead Intermediary to the proposed Intermediary based upon the criteria in Rule 19.4 and indicate whether the Intermediaries concur with the change. The Group Representative must send a copy of such motion to the current and proposed Lead Intermediary. If the parties cannot reach

agreement, the Intermediaries may file an objection setting out their reasons, and the Board will make the determination.

B. On Motion of Lead Intermediary

The current Lead Intermediary may file a motion to challenge its designation as Lead Intermediary (copying the Group Representative and proposed Lead Intermediary) within 15 days of receipt of the Schedule of Providers and Supporting Documentation. The motion should indicate whether the proposed Lead Intermediary and the Group Representative concur with such request.

19.4 – Criteria for Selection of Lead Intermediary

A. The Intermediary which services the greatest number of Providers in the group, or

B. If various intermediaries service the same number of Providers, the amount in controversy controls.

19.5 – Joining a Group Post Full Formation (42 C.F.R. § 405.1837(e)(4))

The Board has discretion to grant or deny a request to join a fully formed group.

Rule 20 – Group Schedule of Providers with Supporting Documentation – Procedure (Appendix – Model Form G)

20.1 – Filing Requirements

Within 60 days of the full formation of the group (*see* Rule 19), the Group Representative must prepare two Schedules of Providers (Appendix - Model Form G) and two sets of supporting jurisdictional documentation which demonstrates that the Board has jurisdiction over the Providers named in the group appeal (*see* Rule 21). One copy of the Schedule of Providers and jurisdictional documents is to be sent to the Board; the second copy is to be sent to the Lead Intermediary. An additional copy of the Schedule of Providers without jurisdictional documents is to be sent to the appeals support contractor. *[March 2013]*

CAUTION: This is a change from the prior Board practice. *[March 2013]*

20.2 – Intermediary to Initially Review Format

If the Schedule and supporting documentation is not submitted in the proper format as described below, within 15 days of receipt the Intermediary is to return the materials to the Group Representative, along with a cover letter (with a copy to the Board) describing the formatting deficiencies (*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 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 Intermediary to comment on whether jurisdictional problems exist for any given Provider or to identify every potential default in documentation. *[March 2013]*

20.3 – Format (Appendix - Model Form G)

A. Documents Must Be Bound

The Schedule and supporting documents must be bound, tabbed and numbered. Due to storage space limitations, the Board will not accept submissions in three-ring loose-leaf binders.

B. The Schedules and Supporting Documentation Must Correspond

Submit a corresponding document for each entry on the Schedule of Providers (except Column C).

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 initial Form in which this issue was appealed for the first Provider. Exhibit 2B will correspond to line 2, column B and will contain a copy of the initial Form in which this issue was appealed for the second Provider.

Rule 21 – Contents of Group Schedule of Providers and Supporting Documentation

Complete the Schedule of Providers that includes all providers in the group and provide the supporting documentation. The Schedule has two parts, a summary page with columns A-G and supporting documentation under corresponding Tabs A-G.

CAUTION: There are significant changes below regarding the information and supporting documentation required to be submitted with the Schedule of Providers. *[March 2013]*

A. Date of Final Determination

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.

2. Supporting 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 20.3D below for additional documentation requirements for appeals filed from a Revised NPR.

- For appeals of other final determinations (e.g., exception and exemption denials, Federal Register notices, etc.), submit a copy of the final determination or Federal Register being appealed.

- For appeals of the Intermediary's failure to timely issue an NPR, submit a copy of:

    - the certification page of the perfected cost report,
    - the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports,
    - the Intermediary's letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
    - evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and
    - the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items. *[March 2013]*

B. Date of Hearing Request

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, 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 PRRB. *See* 42 C.F.R. § 405.1801(a)(2008).

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, 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. *[March 2013]*

C. Number of Days

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). *[March 2013]*

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).

D. Audit Adjustment Number

1. Schedule – **Column D** – Identify the audit adjustment or determination/authority challenged.

2. Documentation – **Tab D** –

- Provide a copy of the matter appealed (e.g., audit adjustment report or other final determination.)

- For appeals from a **Revised NPR**, you **MUST** also submit a copy of:

    - the NPR immediately preceding the Revised NPR under appeal,
    - the Revised NPR,
    - the Reopening Request that preceded the Revised NPR (if applicable),
    - the Reopening Notice issued by the Intermediary,
    - the Revised NPR workpapers (for the issue(s) under appeal), and
    - any applicable cost report worksheets (e.g., Worksheet E).

- For appeals of Self-Disallowed Items, you **MUST** submit a brief narrative identifying the authority that the Provider is challenging, and a copy of the cost report protested item page, if applicable. For cost reporting periods that end on or after December 31, 2008, the Provider must submit the evidence of protest. (*See* Rule 7.2 and 42 C.F.R. § 405.1835(a)(1)(ii)). *[March 2013]*

E. Amount in Controversy

1. Schedule – **Column E** – Identify the amount in controversy (reimbursement effect).

2. Documentation – **Tab E** – Provide a calculation if the reimbursement effect is different from the audit adjustment.

F. Prior Case Number(s)

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."

2. Documentation – **Tab F** – No corresponding documentation required, but see Tab G below. *[March 2013]*

G. Dates of Direct Add/Transfer

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).

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.) *[March 2013]*

H. Representation Letter

1. Schedule – Not applicable.

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. *[March 2013]*

Rule 22 – Intermediary Review of Group Schedule of Providers

The Lead Intermediary is responsible for reviewing the Schedule of Providers and the associated jurisdictional documentation. This review is to be completed, with written notice to the Board of the Lead Intermediary's findings on jurisdiction, within 60 days of receipt. If minor deficiencies in documentation are identified, the Intermediary is encouraged to contact the Group Representative to provide the opportunity to cure the submission.

The Lead Intermediary 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 (*see* Rule 15) and whether impediments exist. *See* Rule 10.1 for the content and format of the Intermediary's response when a jurisdiction challenge is raised. *[March 2013]*

PART II:
PRE-HEARING PROCEDURES

COMMENTARY: In response to requests for more flexibility in the prehearing process, Rules 23 – 27 introduce a major new option. In the past the Board has established preliminary and final position paper due dates, all on standard timeframes based on the date of filing the appeal (currently 4, 6, & 8 months). This standardized timeline did not take into account the complexities or needs of the particular case and often resulted in the final position paper being filed months or years before the hearing.

The Board is, therefore, offering two options: (1) the Board establishes a standard timeline OR (2) the parties jointly establish the deadlines in a proposed Joint Scheduling Order (JSO) except the final position paper due dates which will be scheduled based on the date of hearing. **CAUTION: Deadlines set by the parties in a JSO become the Board's deadlines and are subject to the same sanctions for failure to comply as other deadlines established by the Board.**

Rule 23 – Duty to Confer - Proposed Joint Scheduling Order (JSO) and Preliminary Position Paper Deadlines

23.1 – General

The regulations give the Board broad authority and flexibility to establish procedures. The regulations at 42 C.F.R. § 405.1853 direct the parties to expeditiously join to resolve 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:

- Jointly agree to a proposed Joint Scheduling Order (JSO), a detailed prehearing schedule (except final position paper due dates which will be based on the hearing date, *see* Rule 27). The JSO is based on the parties analysis of the development needed for their case or,

- If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.

Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.

23.2 – Proposed Joint Scheduling Order (Appendix – Model Form F)

Execute and file a proposed JSO. A proposed JSO is a written scheduling plan covering all prehearing and hearing dates except the final position paper due dates. It must be signed by both parties. (Appendix - Model Form F). **Deadlines set by the parties in a JSO become the Board's deadlines and are, upon motion, subject to sanctions for failure to comply.**

23.3 - Preliminary Position Papers Required if no Proposed JSO is Executed

If, for any reason, the parties do not jointly execute and file a proposed JSO by the due date, 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 these Rules impose preliminary position paper requirements that are more stringent than in the past. Full development of the parties' positions fosters efficient use of the administrative review process and due process. The due dates have been extended to give the parties a better opportunity to develop their case. Because the date for adding issues will have expired and transfers are severely limited, the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position. **CAUTION: Unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the documents), new arguments and documents not included in the preliminary position paper may be excluded at the hearing**.

23.4 – Failure to Timely File

The Provider's preliminary position paper due date will be set on the same day as the proposed JSO due date; accordingly, if neither a proposed JSO nor the Provider's preliminary position paper is filed by such date, the case will be dismissed. If the Intermediary 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 – Proposed JSO and Preliminary Position Paper Extension Requests

Requests for extensions for filing a proposed JSO or the Provider's preliminary position papers 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 before the due date that an extension is granted, and a proposed JSO or position paper is not timely filed, the appeal will be dismissed.

COMMENTARY: Because the Regulations and the Rules require a more detailed statement upon filing an appeal and the parties will have substantially more time than in the past to file a preliminary position paper or JSO, the Board expects requests for extension for filing to be few and be based on compelling reasons. For example, delay in finalizing a proposed JSO because the parties delayed conferring until shortly before the due date would not be considered good cause.

Rule 24 – Proposed JSO Content/Board Acceptance

24.1 – Format/Content

A proposed JSO is a written scheduling plan covering all pre-hearing actions needed for development and a hearing date except the final position paper due dates. Every issue in an appeal when a proposed

JSO is filed 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 hearing. These include a discussion of material facts, legal positions on questions of law, data exchange dates, etc. and failure to comply may result in dismissal of any issue that does not comply. (*See* Rule 41.2.)

Pending requests, such as transfers, requests for abeyance, expedited judicial review (EJR), mediation, jurisdiction challenges, discovery, or other motions, until complete or ruled on favorably by the Board where applicable, do not suspend these requirements. **If a motion or request is not complete or has not been ruled on, you must proceed as if it will not occur or will not be granted.** Effective 7/01/2009, if an issue is not timely addressed as required in this rule because the parties have relied on an incomplete action or a pending request that is not yet ruled on, it is subject to dismissal at any time during the proceedings.

If a Provider intends to transfer an issue to a group, the transfer must be complete (with name, case number of the group to which the transfer was made and the date of the request (*see* Appendix - Model Form D) by the JSO filing date. If no group is available for transfer by the JSO filing date or the Group Representative has not approved transfer into the group, the JSO for that issue must comply with the content requirements in Rule 24.1. If the transfer is not complete and the issue is not fully addressed as required by Rule 24.1, the issue is considered abandoned and dismissed from the case.

NOTE: The above three paragraphs were added to clarify that content requirements for JSOs must be met for each issue in the appeal regardless of any pending motions or requests that, when complete or if granted by the Board, might dispose of the issue or obviate the need for certain actions. *[July 1, 2009]*

The proposed JSO must include the following (s*ee* Appendix - Model Form F):

A. Resolved Issues - Identify any issues that are totally resolved and require no further proof.

B. Conditionally Resolved Issues - For each conditionally resolved claim:

1. Provide a brief statement of the issue.

2. 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 travel expenses were adequately documented -- The issue is conditionally resolved based on the Provider's representation that it will furnish the September 2004 travel logs by June 1, 2008.]

C. Unresolved Issues - For each claim not resolved:

1. Provide a brief statement of the issue.

2. Provide a brief statement of the material facts and indicate whether they are disputed.

3. If the claim cannot be resolved because of a question of law, state each party's legal position and the authorities relied on.

4. Identify the documentation exchanged to date.

5. 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).

6. Once the JSO is approved by the Board, the parties may modify JSO deadlines only by their signed, written agreement. An e-mail confirmation or faxed signature is sufficient to signify agreement. A modification of the hearing date 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. The Board will consider the agreed upon dates as deadlines and failure to meet the deadlines, upon objection, may result in Board action subject to 42 C.F.R. § 405.1868, including, but not limited to, exclusion of evidence or dismissal.

D. Identify a Mutually Agreed Upon Month and Year to Set a Hearing

E. Signatures - Both the Provider and Intermediary representatives must sign the document.

24.2 – Proposed Hearing Date

The Board will make every effort to accommodate the requested hearing month and year. The Board typically will not schedule a case less than a year after the filing of the appeal unless a special circumstance exists. [NOTE: The Board however, will consider accelerated hearing requests (*see* Rule 31) at any time.]

24.3 – Board Responses to Proposed JSO

A. Issuance of Notice of Hearing - Unless the Board notifies the parties that the proposed JSO is rejected, the Board will issue a Notice of Hearing via e-mail setting the hearing date and final position paper dates. The issuance of a hearing date on or after the requested hearing date obligates the parties to comply with their agreed deadlines. Any deadlines not addressed by the proposed JSO (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 proposed JSO 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 proposed JSO, the representative should contact the Board to ensure it was received and processed. *[March 2013]*

B. Rejection of Proposed JSO 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. *[July 1, 2009]*

24.4 – Failure to Meet JSO Deadlines

Upon written motion (*see* Rule 44), or on the Board's own motion, the Board may exclude evidence, dismiss the case or an issue, or take other appropriate action for failure to meet the deadlines of the JSO, including deadlines modified by written agreement. *See* 42 C.F.R. § 405.1868). *[July 1, 2009]*

Rule 25 – Preliminary Position Papers

COMMENTARY: Under the Regulations effective August 21, 2008, all issues will have been identified well in advance of the due date for preliminary position papers. Unlike the prior practice, preliminary position papers now are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

To address complaints under the previous Rules that the parties have not had sufficient time to develop meaningful position papers, upon publication of these Rules, the Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the Provider, twelve months for the Intermediary and fifteen months for the Provider's response. The Board may modify these timelines as appropriate for the particular matter appealed (e.g., *see* Rule 50 Children's GME appeals.) As the Board and the parties gain more experience with this process, the timeframes may be modified.

25.1 – Content: The text of the Preliminary Position Papers must include the following:

A. Provider's Preliminary Position Paper

1. For <u>each</u> issue, state the material facts that support your claim.

2. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting your position.

3. Provide a conclusion applying the material facts to the controlling authorities.

B. Intermediary's Responsive Preliminary Position Paper

1. Identify any jurisdictional challenges not previously raised.

2. Identify issues that have been fully resolved and require no further proof.

3. For each issue that has not been fully resolved, identify which material facts or legal principles relied on by the Provider are undisputed or which material facts the Intermediary is without sufficient knowledge to agree or dispute.

4. State the basis for the disputed facts and legal principles.

5. Identify any additional documentation required for resolution.

6. State the material facts that support the Intermediary adjustments.

7. Identify the controlling authorities (e.g., statutes, regulations, policy, or case law) supporting the Intermediary's position.

8. Provide a discussion of how the controlling authorities apply to the material facts.

C. Provider Response to Intermediary Preliminary Position Paper

1. Address rebuttal or Intermediary arguments not previously addressed.

2. Attach documentation not previously furnished with the Provider's preliminary position paper that is responsive to arguments raised by the Intermediary in its responsive preliminary position paper.

25.2 – Preliminary Documents:

A. General: With the preliminary position papers, the parties must exchange all available documentation as preliminary exhibits to fully support your position. The Intermediary must also give the Provider all evidence the Intermediary considered in making the determination (s*ee* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Intermediary believes is necessary for resolution which has not been submitted by the Provider.

B. Unavailable and Omitted Preliminary Documents: If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

C. Preliminary Documentation List: Parties must attach a list of the exhibits exchanged with the preliminary position paper.

25.3 – Filing Requirements to Board

Parties should file with the Board only (1) the cover page of the preliminary position paper, (2) the preliminary documentation list, and (3) a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Do not file any other documents with the Board.

25.4 - Joint Scheduling Orders Filed after the Preliminary Position Papers

If the parties initially filed preliminary position papers instead of a proposed JSO (*see* Rule 23), they may nevertheless file a proposed JSO after the preliminary position papers are filed. Generally, such JSOs will supersede the rules establishing other discovery/documentation exchange deadlines

established by the Board or these rules but will not postpone a scheduled hearing date unless approved by the Board. Failure to meet the agreed discovery/documentation exchange deadlines of the proposed JSO may, upon written motion, lead to the exclusion of evidence or other sanctions. *See* 42 C.F.R. § 405.1868.

COMMENTARY: The Board encourages the parties to develop their case on an agreed schedule; however, a JSO will not be approved where it appears it is filed merely to delay the hearing. If the preliminary position papers indicate that further development of information is needed, a JSO should be promptly developed.

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 dispute. 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 person from whom discovery is requested and on the opposing party; it is NOT 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 JSO approved by the Board, including the parties' written modifications.

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

- the date the request was served. The date the request was sent should be verifiable (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 their address, and
- signature of the representative of record and the date signed.

26.3 – Motions to Compel Discovery or for Protective Orders

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

- A copy of the discovery request. If only parts of the request are in dispute, excerpts plus the signature page and cover page to indicate the source of the excerpt may be sufficient.
- A copy of the disputed response, 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/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. 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 35.5 for use of deposition testimony at a hearing.

Rule 27 – Final Position Papers

27.1 – General

The final position paper should reflect the refinement of the issues from the preliminary position paper or proposed JSO. 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 Intermediary and 30 days for Provider response (optional). Failure to timely file the position papers may result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868.

Exception: If, shortly before the 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 closed the case, the parties are not expected to file final position papers.

27.2 – Content

The final position paper should address each remaining issue including, at a minimum:

a. Identification of each issue and its reimbursement impact.

b. Procedural history of the dispute.

c. A statement of facts that:

   i. Indicates which facts are undisputed.

   ii. Indicates, for each material disputed fact, the evidence that the party asserts supports those facts with supporting exhibits and page references.

d. Argument and Authorities – A thorough explanation of the party's position of how the authorities apply to the facts.

27.3 – Revised or Supplemental Final Position Papers

Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, 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 – Arguments Expanding the Scope of Final Position Papers

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

27.5 – Hearing Exhibits Attached to the Final Position Paper

Attach, in the format stated below, the hearing exhibits necessary to support your position.

27.6 – Size, Spacing, Binding, Tabbing, and Numbering of Position Papers

A. Size - Use 8 ½ x 11 paper.

B. Numbering - Number every page of the position paper and number the pages of all exhibits.

C. Hearing Exhibit Identification - Separate and number exhibits by tabs with identification as either Provider (P-1, P-2) or Intermediary exhibits (I-1, I-2)

D. Legible Copies - Exhibits must be legible.

E. Exhibit List - List each document attached as an exhibit and indicate the tab number.

F. Binding - Binding must be suitable for the thickness of the position paper. The document should remain open easily with the text unobscured by binding. Because of space limitations, do not send position papers in three ring binders.

G. Number of Copies and Time for Filing -

1. Record Copies: The original paper with exhibits is to be filed with the Board and one copy including exhibits is to be simultaneously served on the opposing party.

2. Board Member Copies: The parties are to furnish 5 additional copies of the previously filed final position paper (and/or the revised or supplemental final position papers) and attach the hearing exhibits. Do not submit the Board members' copies at the time of

filing the final position paper. The Board copies must be received at the Board 7-10 business 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. *[March 2013]*

H. Confidential Information -

1. 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, or other information that identifies individuals.

2. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (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, submit a sealed envelope containing the confidential information with a cross reference to the non-identifying sequential numbers.

Rule 28 – Witness List

A witness list must be filed with the Board and served on the opposing party at least 30 days before the hearing date. The list must identify each witness, the witness' relationship to the party, and the nature of the testimony.

If a party intends to qualify a witness as an expert (*see* Rule 34), designate his/her field of expertise and state the subject of the testimony. The following must also be forwarded:

- 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.

Rule 29 – Status/Pre-Hearing Conferences (42 C.F.R. § 405.1853(c))

The Board may conduct a status conference at any time on the Board's own motion or request of either party to the Board Advisor. 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 <u>are expected to have discussed the following with each other prior to a pre-hearing conference with the Board</u>:

- Issues remaining
- Amount in controversy for each issue
- Status of settlement discussions and potential for further settlement
- Stipulations
- Evidentiary issues
- Witnesses
- Documentary evidence

- Whether a request will be made for persons to appear by telephone
- Estimated length of hearing
- Audio and visual needs
- Accommodations for disabled visitors

PART III:
HEARINGS AND DECISIONS

Rule 30 – Hearing Dates/Postponements

30.1 – Notice of Board Hearing

The Board will issue a Notice of Hearing via e-mail setting the hearing date and final position paper due dates. The hearing date established by this notice will serve as the initial hearing date that governs deadlines for final position papers (Rule 27); 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.

NOTE: The Board began sending the Notices of Hearing electronically in July 2009, so the case representative should expect to receive them in this manner at the e-mail address on file with the Board. *[March 2013]*

30.2 – Dismissal for Failure to Appear

Except for good cause beyond a Provider's control, the case will be dismissed for failure to appear at the hearing.

30.3 – Postponements/Scheduling Conflicts

A. General - The Board will consider, but will not routinely grant, postponement requests of a scheduled hearing date. The Board expects the parties to be ready for hearing or have filed by the scheduled hearing date a statement signed by both parties that they have entered into an administrative resolution which is pending approval by the ultimate approving authority (e.g., BCBSA or CMS). 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 not generally warrant a postponement for either party.

B. Request Content - The written request must be received by the Board in advance of the hearing. The request must contain the following:

1. The reason the parties are not ready for hearing.

2. An explanation (include dates and events) how the parties have worked together to settle or narrow the issues.

3. List the actions needed to be ready for hearing.

4. Whether both parties concur with the postponement request.

5. A proposed month and year in which to reschedule the case.

C. **Requests due to Schedule 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 notify the Board as soon as possible and brief the details of the conflict (e.g., the name and case number and the court where an appearance is required). The Board will consider promptly filed, reasonable requests, to reschedule the case to a nearby (earlier or later) date.

Rule 31 – Requesting Accelerated Hearing Date

31.1 – Request

When a party is fully prepared to present its case, it may request that the case be set at the earliest possible date (or within a specified range of dates). The request should demonstrate that the case has no impediments to a hearing (such as outstanding motions or discovery requests), and documentation exchange is complete. 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 the request, the parties are expected to meet any deadlines that may need to be accelerated to accommodate the accelerated date (*see* Rule 30). Hearing dates will be considered firm.

Rule 32 – Methods of Appearance

32.1 – General Rule - In-Person Hearing

The parties' representatives and witnesses are expected to appear in person unless the Board approves an alternative forum. Except as the Board may otherwise designate, Board hearings are held at the Board's office at 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244.

32.2 – Telephone Hearing

A. **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 fact issues and witnesses that requires minimal reference to exhibits. A telephone hearing should not exceed 2 hours.

B. **Witnesses in a Telephone Hearing -** Remote 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, the individuals who are not testifying may be required to leave the room. It is the responsibility of the party calling a remote witness to ensure that the witness has available both parties' organized and labeled exhibits.

32.3 – Record Hearing

A. **Type of Cases -** In cases involving only legal interpretation or very limited fact disputes, and the 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 disputed and/or the credibility of witnesses may be an 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, telephonic, or video hearing.

B. Record Requirements - To be approved for a record hearing, the record must be complete and well organized. Position papers must clearly reference specific evidence on which the parties rely, including the exhibit number and page. The record must contain stipulations regarding all undisputed facts and principles of law.

C. Notice of Record Hearing - Upon approval for a record hearing, the Board will notify the parties of a date for closure of the record. No additional evidence or arguments may be presented after such time except on written motion.

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 expected to be presented during the examination of their witnesses.

33.4 – Witness Examinations

A. 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. Witness' 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.

Upon receipt of the opposing party's witness list, if you wish to ensure a witness on the list will appear, the Board strongly encourages the parties to obtain a written agreement that the witness will actually attend the hearing without the need for a subpoena. If no agreement can be reached, the party may request that the Board issue a subpoena requiring the witness's attendance.

B. 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 a witness.

C. 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.

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

E. Rebuttal Witnesses - Rebuttal witnesses will be permitted at the discretion of the Board.

33.5 – Closing Arguments

If testimony has been presented, the Board encourages comprehensive post hearing briefs (*see* Rule 36) but permits brief closing arguments. Closing arguments should be limited to how the legal authorities apply to the evidence elicited at the hearing. The parties may waive closing argument; however, the Board may request closing argument.

33.6 – Adjournment of Hearing (42 C.F.R. § 405.1851)

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. 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 a 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 report for submission to the opposing representative in accordance with Rule 28.

Rule 35 – Hearing Materials

35.1 – Stipulations

A. 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.]

B. 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.

35.2 – 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 JSO or by these rules. 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, 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.

35.3 – Visual Aids

A. 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 (6 copies) 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.

B. Creation of Visual Aids During a Hearing - A dry erase board, markers, and flip charts are available for use during the hearing. An overhead projector is also available. If these tools are utilized in the hearing, for clarity of the transcribed record, the parties should make a statement summarizing the content of the writings made during the hearing.

35.4 – Summaries

Summaries are encouraged whenever evidence is voluminous or the data is complex. The summary must be based on evidence in the record unless the opposing party agrees to the use of a summary only. The opposing party must be given the summary and have an opportunity to review the source data sufficiently in advance of the hearing to determine if the summary is accurate. If the source documents that support the summary are in the record, they must be identified and cross-referenced.

35.5 – Deposition Testimony and Interrogatories

Deposition testimony may be used at the hearings as if the deponent were present and testifying. At least seven working 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.

35.6 – 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).

35.7 – Prior PRRB testimony

Upon the parties' agreement and subject to the Board's approval, the transcribed testimony from a previous PRRB 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.

35.8 – 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: Briefs, Proposed Decisions, and Evidence

36.1 – General

Post hearing submissions (briefs and proposed decisions) are intended to give the parties an opportunity to summarize the evidence and arguments presented. The Board will set the deadlines for the submissions. The parties must file 6 copies of their submissions. The parties may elect not to file post hearing submissions; however, the Board in most instances strongly encourages their submission.

36.2 – Post Hearing Brief

Similar to the closing argument (Rule 33.5) 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.

36.3 – Proposed Decisions

The format of the proposed decision should include the following: (a) statement of the issue, (b) Medicare statutory and regulatory background, (c) statement of the case and procedural history, (d) contentions of the parties, (e) findings of fact, conclusions of law and discussion, and (f) the recommended decision and order.

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 http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/List-of-PRRB-Decisions.html. *[March 2013]*

Rule 38 – Quorum (42 C.F.R. § 405.1845(d))

A quorum of the Board is required to issue a hearing decision but a quorum is not required to hold a hearing. 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

A. 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.

B. The request must be in writing and contain a detailed explanation why abeyance is appropriate. If the request is based on final disposition of another pending case, state the caption, number, court where a case is pending and the status.

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 e-mail the Board members directly unless otherwise instructed and opposing parties are included in the contact.

40.2 – Ex Parte Communications

A. Procedural Matters - Ex parte communications with Board staff regarding procedural matters are not prohibited. (*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.

B. 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 e-mail upon notice from the parties that the case has been resolved or withdrawn.

41.2 – Own Motion

The Board may also dismiss a case or an issue on its own motion: *[July 1, 2009]*

1. if it has a reasonable basis to believe that the issues have been fully settled or abandoned,

2. upon failure of the Provider to comply with Board procedures (*see* 42. C.F.R. § 405.1868),

3. if the Board is unable to contact the Provider or representative at the last known address, or

4. 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) of 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. In an appeal containing multiple issues, EJR may be granted for fewer than all the issues. The Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days after it determines that 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 included in a separately labeled and easily identified filing. 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.

A. New Requests for Hearing - A request for EJR may be included in an initial hearing request.

- Complete the model form for a new appeal.
- Check the box indicating that the hearing request includes a request for EJR.
- Make the request for EJR in a separate document setting forth the basis for the EJR.
- State in the reference line of the document "Request for EJR."
- Identify the Provider name and number or group name and the fiscal period in issue.
- Copy the Intermediary on the request for EJR.
- Mark the outside of the envelopes or packages "EJR REQUEST."

B. Established Cases - Where a Provider requests EJR in a case that has been previously established.

- State in the reference line of the letter "Request for EJR."
- Identify the Provider or group name.
- Identify the fiscal year.
- Identify the case number.
- Include the provider number for individual appeals.
- Copy the Intermediary on the request for EJR
- Mark the outside of the envelopes or packages "EJR REQUEST."

42.3 – Content of the Request

A Provider must file a written request for EJR that:

- identifies the issue for which EJR is requested,
- demonstrates that there are no factual issues in dispute,
- identifies the controlling law, regulation or CMS ruling, and
- explains why the Board does not have authority to decide the legal question.

Additional Documentation Required for Group Appeal: A Schedule of Providers and jurisdictional documents for each Provider must be filed. If the jurisdictional documents are not tabbed and formatted in accordance with the Board's instructions (*see* Rules 20 and 21) the Board will return them to the Group Representative for correction before considering the EJR request.

Rule 43 – Mediation

43.1 – General

Providers and Intermediaries 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 flexible, confidential process designed to facilitate voluntary resolution. Mediation sessions are conducted by trained mediators from the Office of Hearings. Mediators help to improve communication, help the parties articulate their positions and understand those of their opponent. The mediators facilitate resolution but do not render a decision or dictate a settlement. 90-95% of cases that are mediated are resolved without a hearing.

43.2 – Requesting Mediation

Either party can request mediation at any time. Providers can request mediation at the time the appeal is filed (see Rule 6 and 12) by checking Yes on Model Form A for individual appeals or Model Form B for groups, and attaching a mediation request letter to the initial appeal request. An Intermediary may also request mediation once it receives information on the Provider's appeal. Once a filing is received that indicates a case may be appropriate for mediation, both parties will be contacted to determine if they agree to mediate the case. **The parties must continue to adhere to all due dates until written confirmation is received that the appeal has been approved for mediation.** If an Intermediary

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.)

If the parties agree to mediate the case, the Board staff will notify the parties in writing that the case has been accepted into the mediation program and will suspend all pending due dates. Generally, the mediation session will take place at the office of the Intermediary.

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 both parties at the mediation session.

43.4 – Participating in a Mediation Session

The parties are required to have in attendance at the session someone with the authority to settle 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 settlement negotiations.

At the mediation session, the mediators will typically ask the Provider, as the moving party, to summarize its position first, after which the Intermediary 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 postponement requests.)

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.

I conferred with _____ *concerning the foregoing* _____ *[motion/request and* ____ *he/she* _____ *[does/does not]*

oppose the _____ [motion/request, etc.]

I conferred with _____ concerning the foregoing _____ [motion for extension, request for discovery, etc.] by _____ [give 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 send a response, with relevant supporting documentation, within thirty days from the date that the motion was sent to the Board and opposing party.

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:

- **Individual cases -** The Board requests that the Intermediary preliminarily review the Provider's claimed basis for jurisdiction and raise any identified jurisdiction challenges PRIOR TO filing the proposed JSO or, if applicable, filing the Intermediary's preliminary position paper. (*See* Rule 25.)

- **Group cases -** Within 30 days of receipt of the Board's Acknowledgement of Group Appeal, the current Lead Intermediary 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.)

  Also, within 60 days of receiving the Schedule of Providers, the final Lead Intermediary must file a statement regarding whether jurisdiction is proper for each Provider in the group. (*See* Rule 22.)

The responding party must file a response within 30 days of the Intermediary's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record. *[March 2013]*

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 new regulations and these Board rules establish the expectation that intermediaries to 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.

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 – Reinstatement

46.1 – 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 Rules 46.2 and 46.3 below. [*July 1, 2015*]

46.2 – Withdrawals As a Result of Administrative Resolution or Agreement to Reopen

A. 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 Intermediary 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). [*July 1, 2015*]

B. Reopening

Upon written motion, the Board will also grant reinstatement of an issue(s)/case if a Provider requested to withdraw an issue(s) from its case because the Intermediary 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 the correspondence from the Intermediary where the Intermediary agreed to reopen the final determination for that issue(s). [*July 1, 2015*]

46.3 – 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, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion. [*July 1, 2015*]

Rule 47 – Subpoenas

47.1 – 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 sent via overnight mail or delivery service
- have the outside of the envelope marked "SUBPOENA REQUEST"
- be sent to the following:
    - the Board,
    - the individual to be subpoenaed (or the custodian of records being subpoenaed), and
    - all parties to the appeal
- state if the individual is requested to appear in person or by telephone; 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 either upon notice of the request or upon issuance of the subpoena, if the Board approves the request.

47.2 – Response

The party or nonparty has 15 days from the date the subpoena was received to respond to the subpoena request.

Rule 48 – Withdrawal of an Appeal or Issue within an Appeal

A Provider's request to withdraw an issue(s) or case must be in writing. It is the Provider's responsibility to withdraw: (1) an issue(s) or case that the Provider no longer intends to pursue; (2) an issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution; (3) an issue(s) for which the Intermediary has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Intermediary where the

Intermediary agreed to that reopening; and (4) a case in which all issues have been handled, whether by 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 Intermediary'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 that the Board will not issue a decision to acknowledge the withdrawal of an issue(s) if the withdrawal does not result in the closure of the case. [*July 1, 2015*]

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, and the Bureau of Health Profession. (*See* http://bhpr.hrsa.gov/childrenshospitalgme/)

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 (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

A. 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.

B. Where to File

The Provider Reimbursement Review Board
ATTN: PRIORITY CHGME
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670

C. Telephone Notice to Board

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

D. No Supporting Documentation to Board with Initial Filing

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

E. Other Parties to Receive Notice of Appeal and Supporting Documents

A copy of the hearing request and all documents that support the Provider's claim for reimbursement must be sent to:

Department of Health & Human Services
Office of General Counsel – Public Health Division
Room 4A-63 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-7844
(301) 443-2639 (fax)

The Office of General Counsel represents the agency in CHGME cases before the Board. Mark the outside of the envelope "PRIORITY CHGME APPEAL."

50.3 – Filing CHGME Appeal: Content and Format

The appeal must contain the following:

a. Provider name and complete address;
b. Provider number;
c. Fiscal year end cost report from which FTE count was reviewed;
d. Fiscal year ends to which the three-year rolling average applies;
e. A copy of the "CHGME Program Payment Assessment of Full-Time Equivalent Resident Count";
f. The name, address, telephone number, e-mail address and facsimile number of the hospital contact;
g. A complete statement of the issues;
h. If the Provider is represented by someone other than an officer or owner, include a letter authorizing representation on the Provider's letterhead signed by an officer or owner.

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 27.

50.6 – Public Health Service Response to CHGME Appeal

The response to the CHGME appeal is to conform to rules relating to other appeals. 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM A – INDIVIDUAL APPEAL REQUEST

Date of Request: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Intermediary/MAC: _____

1. **Date of Notice of Final/Revised Determination:** _____

   Type of Final Determination: _____ Notice of Program Reimbursement (NPR)
   (Check one) _____ Revised NPR
   _____ Exception Determination
   _____ Federal Register Notice
   _____ Failure to Issue a Timely Determination
   _____ Other (Specify: _____)

   YOU MUST ATTACH A COPY OF THE FINAL/REVISED DETERMINATION UNDER A **TAB LABELED 1**.

   *** If appealing from a Revised NPR**, you **MUST** also provide copies of: (1) the NPR immediately preceding the Revised NPR under appeal, (2) the Reopening Request that preceded the Revised NPR (if applicable), (3) the Reopening Notice issued by the Intermediary, (4) the Revised NPR workpapers (for the issue(s) under appeal), and (5) any applicable cost report worksheets (e.g., Worksheet E). *See* Rule 7.1.

   *** If claiming Intermediary/MAC failed to issue a timely Final Determination,** state the date the cost report was sent to the Intermediary: _____. You **MUST** also include copies of: (1) the certification page of the perfected or amended cost report, (2) the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports, (3) the Intermediary's letter or e-mail acknowledging receipt of the as-filed and any amended cost reports, (4) evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and (5) the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items. *See* Rule 7.4.

   *** If receipt of Final/Revised Determination is more than five days after date of determination,** state date received: _____. You **MUST** also include a copy of documentation to support the actual date of receipt.

2. **Does this Request include a request for Expedited Judicial Review? _____ YES _____ NO**
   NOTE: A request for EJR must be submitted in a separate document and "EJR Request" must be marked on the outside of the envelope.

3. **Is the Provider requesting Mediation? _____ YES _____ NO**
   NOTE: If yes, a request must be submitted in a separate document.

4. **Provider Information:**

   Provider Name: _____
   Provider Contact/Title: _____
   Provider Address: _____
   _____
   _____
   Provider Telephone Number: _____
   Provider Fax Number: _____
   E-mail Address: _____

5. **Is this Provider commonly owned or controlled? _____ YES _____ NO**
   NOTE: If yes, identify the following contact information for the parent organization:

   Corporation Name: _____
   Contact Person at Corporation: _____
   Corporation Address: _____
   _____
   _____
   Telephone Number: _____
   Fax Number: _____
   E-mail Address: _____

6. **Intermediary/MAC Information:**

   Intermediary/MAC Name: _____
   Intermediary Address: _____
   _____
   _____
   Intermediary/MAC Code (from NPR, if known)**:** _____

7. Representative Information (if applicable):

Representative Name: _____

Company Name: _____

Company Address: _____

_____

_____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

NOTE: If you are filing as a representative, YOU MUST ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4.

8. Issue(s) Appealed:

UNDER A **TAB LABELED 3**, YOU MUST SUBMIT A STATEMENT OF THE ISSUE(S). The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).

Total Amount in Controversy for all Issues: _____

CERTIFICATIONS

A. 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.

Printed Name: _____

Title: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

B. 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 calendar year covered in this request. *See* 42 C.F.R. § 405.1835 (b)(4)(i).

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

C. I certify that a copy of this Request (and any supporting documentation) was sent by (**Check one**)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Intermediary/MAC on this _____day of _____, 2_____.

Certified Mail or Tracking Number: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM B – GROUP APPEAL REQUEST

Date of Request: _____

Proposed Group Name: _____

Fiscal Year Ended: _____

Intermediary/MAC: _____

1. **Type of Group (Check One):**

   _____ **Optional** (providers are not commonly owned or controlled)

   _____ **Mandatory** (providers are commonly owned or controlled – Common Issue Related Parties (CIRP) Group)

2. **If mandatory group, provide the following contact information for the parent organization:**

   Corporation Name: _____

   Contact Person at Corporation: _____

   Corporation Address: _____

   _____

   _____

   Telephone Number: _____

   Fax Number: _____

   E-mail Address: _____

3. **Preliminary Schedule of Providers:**

   UNDER A **TAB LABELED 1**, YOU MUST INCLUDE A LIST OF PROVIDERS THAT ARE APPEALING THE ISSUE USING THE FORMAT FOR THE SCHEDULE OF PROVIDERS, WHICH CAN BE FOUND IN THE APPENDIX - MODEL FORM G. Complete the information required by each column including the original case number, if applicable.

   Unless EJR is requested, only one provider in a CIRP group or two providers in an optional group must supply the representation letter and jurisdictional documentation required in the Schedule of Providers (*See* Rules 20-21) to establish jurisdiction for a group appeal. Jurisdictional documentation for all providers must be furnished in the final Schedule of Providers.

4. **Is this group fully formed** (does it include all providers that will be in the group, and have all the providers received their final determinations)? _____ **YES** _____ **NO**

5. **Does this Request include a request for Expedited Judicial Review?** _____ **YES** _____ **NO**
NOTE: A request for EJR must be submitted in a separate document and "EJR Request" must be marked on the outside of the envelope.

6. **Is the Group requesting Mediation?** _____ **YES** _____ **NO**
NOTE: If yes, a request must be submitted in a separate document.

7. **Group Representative Information:**

Representative Name: _____
Company Name: _____
Company Address: _____
_____
_____
Phone Number: _____
Fax Number: _____
E-mail Address: _____

8. **Lead Intermediary/MAC Information:**

Intermediary/MAC Name: _____
Intermediary Address: _____
_____
_____
Intermediary/MAC Code (if known)**:** _____

9. **Common Group Issue Appealed (only one issue per group):**

NOTE: The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS Rulings that is common to each provider in the group. *See* 42 C.F.R. § 405.1837(a)(2) and PRRB Rules 13 and 8.

UNDER A **TAB LABELED 2**, YOU MUST SUBMIT A STATEMENT OF THE GROUP ISSUE. The statement of the issue must conform to the requirements of the regulations found at 42 C.F.R. § 405.1837 et seq. and the Board's Rules and must include: (1) a description of the issue; and (2) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).

CERTIFICATIONS

A. **For Optional and Mandatory (CIRP) Groups:**
I hereby certify that the group issue filed under this appeal is not pending in any other appeal for the same period for the same provider, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

Printed Name: _____

Title: _____

Signature: _____
(Group Representative)

Date: _____

B. **For Optional (Non-CIRP) Groups Only:**
I hereby certify to the best of my knowledge that there is no other provider to which this provider is related by common ownership or control that has a pending request for a Board hearing on the same issue contained in this hearing request for a cost reporting period that ends in the same calendar year cover in this hearing request. *See* 42 C.F.R. § 405.1837(b)(1)(i).

Printed Name: _____

Title: _____

Signature: _____
(Group Representative)

Date: _____

C. I certify that a copy of this Request (and all supporting documentation) was sent by (**Check one**)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Lead Intermediary/MAC on this _____day of _____, 2_____.

Certified Mail or Tracking Number: _____

Signature: _____
(Group Representative)

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM C – REQUEST TO ADD ISSUE(S) TO AN INDIVIDUAL APPEAL

Date of Request: _____

Individual PRRB Case No.: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Date of Original Hearing Request: _____

A provider may add issues to an appeal provided the request conforms to the requirements of 42 C.F.R. § 405.1835(c).

1. **Issue(s) Being Added to Case:**

   _____

   _____

   UNDER A **TAB LABELED 1** YOU MUST SUBMIT A STATEMENT FOR EACH ISSUE BEING ADDED TO THIS APPEAL. The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other information to demonstrate provider preserved its right to appeal; (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (Cite statutes, regulations and/or manual provisions).

2. **Does this Request include a request for Expedited Judicial Review? _____ YES _____ NO**
   NOTE: A request for EJR must be submitted in a separate document and "EJR Request" must be marked on the outside of the envelope.

3. **Is the Provider requesting Mediation? _____ YES _____ NO**
   NOTE: If yes, a request must be submitted in a separate document.

4. **Is this issue being transferred concurrently to a group appeal? _____ YES _____ NO**
   NOTE: If yes, you must attach **Model Form D.**

5. **Representative Information:**
   Are you the representative on file for this individual appeal? _____ YES _____ NO
   NOTE: If you are not the representative on file or who established this appeal, then you must attach an authorization letter signed by an official of the provider.

CERTIFICATIONS

A. I certify that none of the issues added to 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.

Printed Name: _____

Title: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

B. 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 calendar year covered in this request. *See*, 42 C.F.R. § 405.1835(b)(4)(i).

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

C. I certify that a copy of this Request (and any supporting documentation) was sent by (**Check one**)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Intermediary/MAC on this _____day of _____, 2_____.

Certified Mail or Tracking Number: _____

Signature: _____
(Provider Owner/Officer/Director or Representative)

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
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MODEL FORM D – REQUEST TO TRANSFER ISSUE TO A GROUP APPEAL
*YOU **MUST** FILE AN ORIGINAL AND 1 COPY OF THIS FORM (MARKED **COPY**)*

Date of Request: _____

Prior PRRB Case No(s).: _____

*(**NOTE:** You **MUST** provide full transfer history if issue has presided in more than one case.)*

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

1. **Describe the Issue that is being transferred and include the relevant audit adjustment number, if applicable:**

   _____

   _____

2. **Is this the last issue remaining in the individual appeal? _____ YES _____ NO**
   If so, check Yes and the individual case will be closed due to the transfer of the remaining issue.

3. **What is the PRRB Group Case Number and name of the group to which the issue is being transferred?**

   Group Case No.: _____

   Group Case Name: _____

   NOTE: If the group appeal to which you are requesting to transfer has not yet been assigned a case number, please provide the following information OR attach a copy of the group appeal request:

   Date of Group Appeal Request: _____

   Group Representative's Name: _____

   Group Representative's Company: _____

   Proposed Name of Group Appeal: _____

   ***NOTE**: Transfers using this form can **ONLY** be made to existing group appeals and to group appeals that have been requested previously, but which have not yet been assigned a case number by the Board. If you attempt to transfer an issue to a group case that has not yet been requested to be established, your transfer request will not be processed and the issue will remain in the individual appeal.*

4. **Is this a commonly owned or controlled Provider?** **_____ YES** **_____ NO**
   NOTE: If yes, identify the following contact information for the parent organization:

   Corporation Name: _____
   Contact Person at Corporation: _____
   Corporation Address: _____
   _____
   _____
   Telephone Number: _____
   Fax Number: _____
   E-mail Address: _____

5. **Is the group a mandatory Common Issue Related Party (CIRP) group appeal?** **_____ YES** **_____ NO**

6. **Is the Provider a member of the CIRP?** **_____ YES** **_____ NO**

NOTE: (*See* Rules 12.5 and 12.6.) Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least $50,000. Providers that are not part of a CIRP group may not join a CIRP appeal. Providers that are part of CIRP organizations may not join an optional group 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.

7. **If you are a CIRP provider who is attempting to transfer an issue to a group appeal involving independent hospitals, you must document why this action is appropriate in the space below** (An example of an appropriate response is "The provider certifies that no other commonly owned providers have, nor will have the same issue pending for the same calendar year."

   _____
   _____
   _____

8. Please check below the statement which describes when the issue was added to this appeal and attach the required documentation to support that the issue was timely raised consistent with the checked box.

NOTE: *The issue must be included in the individual appeal* ***before*** *it can be transferred to a group appeal. See 42 C.F.R. § 405.1835.*

_____ The issue was included in the original appeal request. In order to confirm that this issue was included in the original appeal request, you **MUST ATTACH a copy of the original appeal request and/or a copy of Model Form A – Individual Appeal Request (including attachment with the statement of issue(s)).**

_____ The issue was added to the Provider's pending appeal. In order to confirm that this issue was added to the pending appeal, you **MUST ATTACH a copy of the letter requesting to add the issue and/or a copy of Model Form C – Request to Add Issues Request (including attachment with the statement of issue(s)).**

9. Are you the representative for the individual appeal from which the issue is being transferred? **_____ YES _____ NO**

NOTE: *If you answered "NO", the Provider/Representative* ***MUST SIGN*** *Section A of the Certification Page and you will be required to submit an authorization of representation signed by an official of the Provider when you submit the final Schedule of Providers with the associated jurisdictional documentation.*

CERTIFICATIONS

A. I certify that this issue is not pending in any other appeal for the same period, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal. The Provider has been notified that this issue is being transferred to the group appeal case number _____. The Provider agrees with this transfer.

Printed Name: _____

Title: _____

Signature: _____
(Provider/Representative Transferring Issue)

Date: _____

B. I have reviewed the regulations at 42 C.F.R. § 405.1837, the Board Rules and consulted with the Provider/other representative identified on this form. I have a good faith belief that this transfer request meets the single common issue requirement for a group appeal.

Printed Name: _____

Title: _____

Signature: _____
(Group Representative)

Date: _____

C. I certify that a copy of this Request (and any supporting documentation) was sent by (**Check one**)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Lead Intermediary/MAC for the group (if known) and the local Intermediary for the Provider (if different) on this _____day of _____, 2_____.

Certified Mail or Tracking Number(s): _____

Signature: _____
(Group Representative)

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM E – REQUEST TO JOIN AN EXISTING GROUP APPEAL: DIRECT APPEAL FROM FINAL DETERMINATION

Date of Request: _____

Provider Name: _____

Provider Number: _____

Fiscal Year Ended: _____

Intermediary/MAC: _____

1. **What is the PRRB Group Case Number and name of the group to which the issue is being transferred?**

   Group Case No.: _____

   Group Case Name: _____

   NOTE: If the group appeal to which you are requesting to transfer has not yet been assigned a case number, please provide the following information OR attach a copy of the group appeal request:

   Date of Group Appeal Request: _____

   Group Representative's Name: _____

   Group Representative's Company: _____

   Proposed Name of Group Appeal: _____

   ***NOTE**: Transfers using this form can **ONLY** be made to existing group appeals and to group appeals that have been requested previously, but which have not yet been assigned a case number by the Board. If you attempt to transfer an issue to a group case that has not yet been requested to be established, your transfer request will not be processed and the issue will remain in the individual appeal.*

2. **Date of Notice of Final/Revised Determination:** _____

   Type of Final Determination:
   (Check one)

   _____ Notice of Program Reimbursement (NPR)
   _____ Revised NPR
   _____ Exception Determination
   _____ Federal Register Notice
   _____ Failure to Issue a Timely Determination
   _____ Other (Specify: _____)

YOU **MUST** ATTACH A COPY OF THE FINAL/REVISED DETERMINATION UNDER A **TAB LABELED 1**.

*** If appealing from a Revised NPR**, you **MUST** also provide copies of: (1) the NPR immediately preceding the Revised NPR under appeal, (2) the Reopening Request that preceded the Revised NPR (if applicable), (3) the Reopening Notice issued by the Intermediary, (4) the Revised NPR workpapers (for the issue(s) under appeal), and (5) any applicable cost report worksheets (e.g., Worksheet E). *See* Rule 7.1.

*** If claiming Intermediary/MAC failed to issue a timely Final Determination,** state the date the cost report was sent to the Intermediary: _____. You **MUST** also include copies of: (1) the certification page of the perfected or amended cost report, (2) the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports, (3) the Intermediary's letter or e-mail acknowledging receipt of the as-filed and any amended cost reports, (4) evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and (5) the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items. *See* Rule 7.4.

*** If receipt of Final/Revised Determination is more than five days after date of determination,** state date received: _____. You **MUST** also include a copy of documentation to support the actual date of receipt.

NOTE: Joinder to an existing group must meet the timeliness requirements of 42 C.F.R. § 405.1837(g).

3. Description of Issue (include the relevant audit adjustment number, if applicable):

_____

_____

4. Provider Information:

Provider Name: _____

Provider Contact/Title: _____

Provider Address: _____

_____

_____

Provider Telephone Number: _____

Provider Fax Number: _____

E-mail Address: _____

5. **Is this Provider commonly owned or controlled?** **_____ YES _____ NO**
   NOTE: If yes, identify the following contact information for the parent organization:

   Corporation Name: _____
   Contact Person at Corporation: _____
   Corporation Address: _____
   _____
   _____
   Telephone Number: _____
   Fax Number: _____
   E-mail Address: _____

6. **Is the group a mandatory Common Issue Related Party (CIRP) group appeal?** **_____ YES _____ NO**

7. **Is the Provider a member of the CIRP?** **_____ YES _____ NO**

NOTE: (*See* Rules 12.5 and 12.6.) Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers and for which the amount in controversy for cost reporting periods ended in the same calendar year is, in the aggregate, at least $50,000. Providers that are not part of a CIRP group may not join a CIRP appeal. Providers that are part of CIRP organizations may not join an optional group 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.

8. **If you are a CIRP provider who is attempting to transfer an issue to a group appeal involving independent hospitals, you must document why this action is appropriate in the space below** (An example of an appropriate response is "The provider certifies that no other commonly owned providers have, nor will have the same issue pending for the same calendar year."

   _____
   _____
   _____

9. **Representative Information (if applicable):**
   NOTE: If you are filing as a representative, YOU **MUST** ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4.

CERTIFICATIONS

A. I certify that this issue is not pending in any other appeal for the same period, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal. The Provider has been notified that this issue is being added to the group appeal case number _____. The Provider agrees with request.

Printed Name: _____

Title: _____

Signature: _____
(Provider/Representative Adding Issue)

Date: _____

B. I have reviewed the regulations at 42 C.F.R. § 405.1837, and the Board Rules and consulted with the Provider/other representative identified on this form. I have a good faith belief that this addition request meets the single common issue requirement for a group appeal.

Printed Name: _____

Title: _____

Signature: _____
(Group Representative)

Date: _____

C. I certify that a copy of this Request (and any supporting documentation) was sent by (**Check one**)

_____ United States Postal Service

_____ Nationally recognized courier. Specify name: _____

to the Lead Intermediary/MAC for the group (if known) and the local Intermediary for the Provider (if different) on this _____day of _____, 2_____.

Certified Mail or Tracking Number(s): _____

Signature: _____
(Group Representative)

Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

MODEL FORM F – PROPOSED JOINT SCHEDULING ORDER

Date of Request: _____

PRRB Case Number: _____

Provider/Group Name: _____

Provider/Group FYE: _____

Provider No(s).: _____

Intermediary/MAC: _____

A. Resolved Issues – Under a TAB LABELED 1, identify appealed issues resolved by the parties.

B. Conditionally Resolved Issues – Under a TAB LABELED 2, identify issues on which conditional resolution has been reached. Include for each conditionally resolved claim:

1. A brief statement of the issue.

2. A description of 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 travel expenses were adequately documented-- The issue is conditionally resolved based on the Provider's representation that it will furnish the September 2004 travel logs by June 1, 2008.]

C. Unresolved Issues – Under a TAB LABELED 3, identify issues that have not been resolved. Include for each unresolved issue:

1. A brief statement of the issue.

2. A brief statement of the material facts and indicate whether they are disputed.

3. For claims that cannot be resolved because of a question of law, briefly state each party's legal position and the authorities relied upon.

4. Listing of documentation exchanged to date.

5. 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)).

[Example: Unresolved Issue 1 is Medicaid Eligible Days –
January 1, 20xx – Provider will submit to Intermediary an updated Medicaid eligible days listing.

February 1, 20xx – Intermediary will have sampled listing and given sampled items to Provider with request for supporting documentation.

March 1, 20xx – Provider will supply all documentation requested by the Intermediary in support of the sample.

March 15, 20xx - Intermediary will have reviewed documentation submitted by Provider in support of sample and will inform Provider of audit findings. Additional documentation requests will be provided by this date.

April 1, 20xx – Provider will respond to audit findings with any additional documentation.

April 15, 20xx – Intermediary will submit finalized adjustments to Provider.

May 1, 20xx – Final Administrative Resolution will be drafted or parties will inform PRRB that an Administrative Resolution cannot be reached.

Also include a timetable for the following actions for any unresolved matters. You may state the date (month/day/year) or express the date as the number of days from an event (e.g., prior to hearing):

Provider's preliminary position paper
Intermediary's preliminary position paper
Exhibit exchange deadline
Witness list deadline
Subpoena requests]

NOTE: Once the JSO is approved by the Board, the parties may modify JSO deadlines only by their signed, written agreement. An e-mail confirmation or faxed signature is sufficient to signify agreement. A modification of the hearing date requires Board approval. The Board will consider the agreed upon dates as deadlines and failure to meet the deadlines, upon objection, may result in Board action subject to 42 C.F.R. § 405.1868, including, but not limited to, excluding evidence or dismissal.

D. Identify a mutually agreed upon month and year for hearing: _____
This date should not be less than 180 days from the last documentation deadline set in C.5 above. (The Board typically will not schedule a case less than a year after the filing of the appeal unless a special circumstance exists; however, the Board will consider accelerated hearing requests (*See* Rule 31) at any time).

E. Signatures – The undersigned have agreed that this document accurately identifies all issues in Case No. _____ and the parties have agreed upon the deadlines set forth in this document. The parties understand that the Board's issuance of a hearing date on or after the requested hearing date in D. above will constitute the Board's acceptance of all other proposed JSO deadlines. All other deadlines and evidence cut offs will be controlled by the parties' JSO unless the Board advises otherwise. The parties must meet all deadlines within the JSO, including agreed upon written modifications, even if the hearing is scheduled later than requested.

Provider Representative:	**Intermediary Representative:**
_____	_____
Print Name	Print Name
_____	_____
Title/Organization	Title/Organization
_____	_____
Signature	Signature
_____	_____
Date	Date

Model Form G: Schedule of Providers in Group

Case No.: _____ Page _____ of _____

Group Name: _____ Date Prepared: _____

Group Representative: _____

Lead Intermediary: _____

Issue: _____

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add / Transfer(s) to Group
1.											
2.											
3.											
4.											
5.											
6.											

Total $ _____

SCHEDULE OF PROVIDERS

Model Form G: Schedule of Providers in Group
Examples

Case No.: _____ Page _____ of _____

Group Name: _____ Date Prepared: _____

Group Representative: _____

Lead Intermediary: _____

Issue: _____

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add / Transfer(s) to Group
Appeal filed before 8/21/2008, issue raised in initial hearing request then transferred to group											
1.	01-0000	Sample Hospital #1 ([redacted], [redacted], AL)	12/31/2005	Cahaba (J-10)	05/25/2007	10/24/2007 (postmark)	152	25	$2,164	08-xxxx	07/01/2009
Appeal filed before 8/21/2008, issue added to individual case before 8/21/2008 then transferred to group											
2.	03-0000	Sample Hospital #2 ([redacted], [redacted], AZ)	06/30/2005	Noridian (J-F)	05/30/2007	11/26/2007 (postmark) 6/15/2008 (postmark)	180 n/a	63	$32,000	08-xxxx	10/15/2008
Appeal filed before 8/21/2008, issue added to individual case after 8/21/2008 but before 10/20/2008 then transferred to group											
3.	09-0000	Sample Hospital #3 ([redacted], [redacted], FL)	06/30/2005	FCSO-FL (J-9)	11/30/2007	05/31/2008 (postmark) 10/15/2008 (receipt)	182[1] n/a	63	$32,000	08-xxxx	10/15/2008
Appeal filed after 8/21/2008, issue added to individual case and transferred to group											
4.	33-0000	Sample Hospital #4 ([redacted], [redacted], NY)	12/31/2005	NGS-NY (J-13)	06/30/2012	12/15/2012 (receipt) 02/18/2013 (receipt)	168 233	50	$109,732	12-xxxx	02/25/2013

[1] Board will calculate the 5-day presumption.

Case No.: _____ Page _____ of _____

Group Name: _____ Date Prepared: _____

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add / Transfer(s) to Group
Appeal filed from a Revised NPR											
5.	05-0000	Sample Hospital #5 ([redacted], [redacted], CA)	12/31/2005	Palmetto c/o FCSO-CA (J-1)	10/13/2011 (R)	03/28/2012	167	R-001	$112,000	12-xxxx	4/28/2012
Appeal filed as a direct addition of Provider into group appeal											
6.	22-0000	Sample Hospital #6 ([redacted], [redacted], MA)	09/30/2005	NHIC Corp, c/o NGS (J-14)	02/15/2012	06/01/2012 (via Model Form E)	106	178	$56,392	Direct Add	06/01/2012
Provider participation in multiple appeals prior to final transfer to current group											
7.	45-0000	Sample Hospital #7 ([redacted], [redacted], TX)	12/31/2005	Novitas (J-H)	09/30/2007	03/28/2008	180	16	$466,627	08-xxxx 07-xxxxG 08-xxxxGC	03/30/2008 10/20/2008 02/25/2013
Appeal from Federal Register Notice (See Rule 7.3)											
8.	36-0000	Sample Hospital #8 ([redacted], [redacted], OH)	12/31/2013	CGS (J-15)	8/31/2012 (date of publication – Note: there is no 5 day presumption)	2/26/2013	179	Protest (*see* Rule 7.2C)	$1,111,000	Direct Add	02/26/2013

Total $1,889,915


1A

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PART A INTERMEDIARY NATIONAL FQHC INTERMEDIARY
REGIONAL HOME HEALTH INTERMEDIARY

RECEIVED OCT 05 2005
MEDICARE

PHONE 805-367-0800

1) Lynne - entire package
2) Reid - 2 page cover letter

September 28, 2005

[redacted]

SUBJECT: NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

Provider Nos. : [redacted]
Reporting Period From: 07/01/00 Through 06/30/01

Dear [redacted]:

We have computed a final settlement of your Medicare cost report after a desk audit. The amount and reason for each audit adjustment, including appropriate references to Medicare Regulations, are stated in the "Adjustment Report" which is part of the audited cost report accompanying this letter.

Attached please find:

Exhibit	Title
A	Summary
B	Appeal Rights
C	Form of Report

Your cost report was due 08/05/02, and was received on 08/07/05 with a postmark date of 08/02/02. The net result of this settlement is $[redacted] **due your facility.**

This amount is scheduled to be paid to your facility. However, if your facility has outstanding liabilities due the Medicare Program, we are obligated to recoup the applicable amounts from the payable above.

UNITED GOVERNMENT SERVICES, LLC.
P.O. Box 9150, Oxnard, California 93031-9150 • Corporate Headquarters located in Milwaukee, WI
A CMS CONTRACTED INTERMEDIARY

[redacted]

Telephone: [redacted]
Fax: [redacted]

March 17, 2006
Certified #7004 2890 8261 4843

Mr. Steve Kirsh, Director
Provider Reimbursement Review Board
Division of Jurisdiction & Case Management
2520 Lord Baltimore Drive, Suite L
Baltimore, Maryland 21244-2670

RE: Request for Hearing
[redacted]
Provider No. [redacted]
FYE: June 30, 2001

Dear Mr. Kirsh:

We request a hearing for the above referenced Provider and reporting period to dispute the following issues to the Medicare Cost Report issued by the Intermediary (United Government Services, LLC.) on September 28, 2005. Please find a copy of the Notice of Program Reimbursement and the Intermediary's adjustment report. As the representative of the Provider, [redacted] has included a letter of representation from the Provider. The sum of the impacts for each issue exceed, the $10,000 threshold established by the Board for an Individual Appeal.

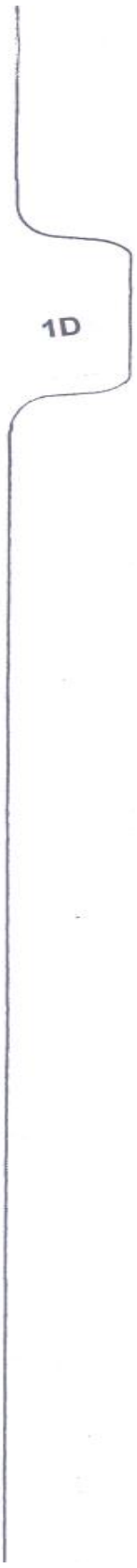
1. MEDICARE BAD DEBTS
Adjustments 28,29, 30 and 41
Effect $ 76,000

The Provider appeals whether the Intermediary was correct in disallowing bad debts for the following issues:

- ($9,665) - Discrepancy between allowed Medi-Medi Crossovers bad debts and actual in Adjustment 30.
- ($66,600) - Unprocessed Inpatient Medi-Medi Crossovers Bad Debts protested in Adjustment 41.

2. TEFRA TARGET AMOUNT (PSYCHIATRIC UNIT)
Adjustment 42 and 51
Effect $2,500

Whether the Intermediary was correct in their determination of the TEFRA Target Amount for this psychiatric unit per 42 CFR §413.40(f)(2)(ii)(A).


1D

ADJ #	WS	P	F	T	LINE	COLUMN	A6/A8 LTR	A6/A8 LINE	EXPLANATION OF AUDIT ADJUSTMENTS	AS REPORTED	INCREASE/ DECREASE	AS ADJUSTED
									RAD Codes 401 & 442. Since Provided did not identify the RAD codes, FI considered all the accounts as either 401 or 442. 42 CFR 413.80, 413.24; CMS PRM1 300. WP: 14-5			
31	S3	1			1	6			HOSPITAL ADULTS & PEDS To adjust total patient days to account for the Labor/Delivery Room days. 42 CFR 413.24; CMS PRM1 2304 WP: 3-2	50211	-766	49445
32	E	A	1		4.03	1			ALLOWABLE DISPROPOR SHARE PERCENTAGE Adjustment is proposed to re-state the DSH Percentage on the basis of the audited DSH eligible days. 42 CFR 412.106; CMS PRM1 2807.2(B)(5) WP: 15-7	9.11	1.98	11.09
33	S3	1			1	5			HOSPITAL ADULTS & PEDS To adjust the T19 days to the audited DSH eligible days. 42 CFR 412.106; CMS PRM1 2205 WP: 15-8	5722	1521	7243
34	S4	1			2	2			UNDUPLICATED CENSUS Count	420	-20	400
34	S4	1			2	5			UNDUPLICATED CENSUS Count	604	-20	584
34	S4	1			2.01	2			UNDUPLICATED CENSUS Count	868	44	912
34	S4	1			21	1				4325	-286	4039
34	S4	1			21	3				583	6	589
34	S4	1			21	4				4	299	303
34	S4	1			21	5				0	46	46
34	S4	1			21	6				1419	-35	1384
34	S4	1			22	1				665600	-43550	622050
34	S4	1			22	3				88475	900	89375
34	S4	1			22	4				600	45500	46100
34	S4	1			22	5				0	7125	7125
34	S4	1			22	6				221130	-5475	215655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9/29/2006

[redacted]
DSH CALCULATION
FYE 6/30/01
PROVIDER NO. [redacted]

Medi-Cal Days	**UGS Calc As of 9/26/05**		**Impact of Dual Eligible Days**		**Impact of Share of Cost Days**	
			7,792		7,792	
			194		194	
Total Paid Days	7,102		7,986		7,986	
Eligible Days - Adult Days (Code 1 & Code 2)	2,939		2,939		2,939	
Eligible Days - Baby & Mother (Code 1 & 2 Moms)	1,257		1,257		1,257	
Less: CWF Pt A Entitled Unpaid Days (Code 1)	(984)		0		0	
Less: Code 2 Adult Days	(263)		(263)		0	
Less: Code 2 Baby Days	(30)		(30)		0	
Less: Code 1 Mom's Admit 1 Day Prior (LRDP Days)	(166)		(166)		(166)	
Additional days found during audit	11					
Less: IP Part B Days (0.1% Total Paid Days)			(8)		(8)	
Less: Audit adj	(32)					
Total Medi-Cal Eligible Days	**9,834**		**11,715**		**12,008**	
Total Patient Days (S-3)	64,310		64,310		64,310	
Less: Total LRDP Days	(766)		(766)		(766)	
Adjusted Hospital Days	**63,544**		**63,544**		**63,544**	
MEDI-CAL PERCENTAGE	**0.15476**		**0.18436**		**0.18897**	
SSI RATIO	**0.11034**		**0.11034**		**0.11034**	
SSI ADJ						
REVISED SSI % PER PROVIDER						
DSH Patient Percentage	0.26510		0.29470		0.29931	
Qualifying Threshold	0.20200		0.20200		0.20200	
Difference	0.06310		0.09270		0.09731	
Percentages	0.82500		0.82500		0.82500	
Line 9 times line 10	0.05206		0.07648		0.08028	
Add On Percentage	0.05880		0.05880		0.05880	
DSH Payment Adjustment Factors	**0.11086**		**0.13528**		**0.13908**	
	0.11090					
	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)
Total Federal Payments	16,571,336	5,865,147	16,695,194	5,565,065	16,695,194	5,565,065
DSH Payment	1,837,761	650,445	2,258,490	752,830	2,322,000	774,000
DSH Reduction Factor	3.0%	1.0%	3.0%	1.0%	3.0%	1.0%
DSH Reduction Amount	(55,133)	(6,504)	(67,755)	(7,528)	(69,660)	(7,740)
Total DSH Amount	1,782,628	643,940	2,190,736	745,302	2,252,340	766,260
Total DSH Payment	**2,426,568**		**2,936,037**		**3,018,600**	
DSH amount, per previous calculation	(2,426,568)		(2,426,568)		(2,936,037)	
Impact	**(0)**		**509,470**		**82,562**	

L:\Grp Appeal\DSH CMS\TCMC 01-05
01

Prepared by [redacted]


1G

file

[redacted]

Telephone: [redacted]
Fax: [redacted]

July 28, 2006
Certified Mail # 7003 1680 0007 1160 9885

Suzanne Cochran Esq., Chairperson
Provider Reimbursement Review Board
2520 Lord Baltimore Drive, Suite L
Baltimore, Maryland 21244-2670

RE: [redacted]
Fiscal Year Ended: June 30, 2001
Provider Number [redacted]8 should be [redacted]
PRRB Case No. [redacted]
Request to transfer an issue to Group Appeal
[redacted]**01 DSH SSI Group Appeal,**
Case No. [redacted]**G**

Dear Ms. Cochran:

The Provider requests to transfer the issue of DSH SSI from the above-referenced individual appeal of the Provider to a group appeal on this issue, Case No. [redacted]G.

The issue to be transferred is whether the Supplemental Security Income (SSI) percentages used in the Disproportionate Share Hospital (DSH) calculation have been understated. The Providers seek to analyze and challenge the underlying data used by the Centers for Medicare & Medicaid Services (CMS) to generate the Providers' SSI percentages for the fiscal years included in this group appeal.

Please contact us if you have any questions.

Sincerely,

[redacted]

Vice President