Provider Reimbursement Review Board Rules

Version 2.0

August 29, 2018

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207

(410) 786-2671
https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/index.html

Table of Contents

PART I:
FILING APPEALS AND
MEDICARE CONTRACTOR 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 Rules Apply to Individual and Group Appeals

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

1.3 Good Faith Expectations

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

1.4 Confidential Information

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

Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (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, do not file into OH CDMS. Separately submit a sealed envelope containing the confidential information with a cross reference to the non-identifying sequential numbers. Any documentation submitted with unredacted PHI or PII (not submitted under seal) will be permanently removed from the record and will not be considered by the Board.

1.5 References to Days

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

1.6 Accessibility Standards

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

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

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

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

2.1 Implementation of Electronic Filing

OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the PRRB. Access to the system is granted as needed based on role. Access to specific cases is limited to the parties of each case, including party representatives. While its use not currently required, the PRRB strongly recommends all parties utilize this new electronic case management tool.

To access OH CDMS, *see* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The webpage includes a link to the CMS Enterprise Portal as well as current registration and user manuals. For any technical system issues, please contact the OH CDMS Help Desk at 1-833-783-8255 or email helpdesk_ohcdms@cms.hhs.gov.

2.2 Correspondence through OH CDMS

2.2.1 Parties’ Submissions to the Board

All appeal requests and additional correspondence, briefings, etc. can be filed directly into OH CDMS. All filings are captured in a Confirmation of Correspondence to document the data entry and document uploads. The electronic filing is the official record of the appeal for all documentation filed on or after the implementation of the system, while previous hard copy documents remain as the official record prior to that date.

Appeal information submitted into OH CDMS **does not** also need to be filed with the Board in hard copy unless the Board directly requests that you do so.

2.2.2 Board Correspondence and Decision Issuances

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

Rule 3 Correspondence Requirements

3.1 PRRB Mailing Address

If documents need to be submitted in hard copy to the Board (e.g., six additional copies of briefs before a hearing), they can be mailed to:

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207

3.2 Delivery of Materials to the Board

Documents should be submitted electronically to the Board through OH CDMS. If hard copies are necessary, or otherwise requested by the Board, they may be submitted in any one of the following ways:

- by regular mail through the United States Postal Service (USPS);
- by express or overnight mail by a nationally-recognized next-day courier (such as USPS' Express Mail, Federal Express, United Parcel Service, etc.); or
- by hand delivery or other courier.

If the parties filed hard copy correspondence, it is their responsibility to maintain evidence of timely filing. The Board does ***not*** accept appeals or other correspondence submitted by email or fax.

3.3 Timely Delivery

Be sure to allow sufficient time for documents to be received in a timely manner.

3.3.1 Electronic Submissions through OH CDMS

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

3.3.2 Hard Copy Submissions

All other submissions must be received in the Board's offices by close of business on the due date. The normal business hours for the mail room are **8:00 a.m. to 4:00 p.m.**, Monday through Friday. The Board suggests that you call ahead for any hand delivery to ensure that someone will be available to accept the delivery, though hand deliveries must also be made during normal business hours.

3.4 Service on Opposing Parties

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

3.4.1 When Both Parties Are Registered for OH CDMS

OH CDMS will notify both parties of all submissions into the system. If both parties are registered for OH CDMS, then the system-generated notice will fulfill the requirement for service on the opposing party.

3.4.2 When One Party Is Not Registered for OH CDMS

If one party is not registered for OH CDMS and opts to submit its appeal and other documentation in hard copy to the Board, then that party must:

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

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

3.5 Caption and Case Number on All Submissions

All filings and correspondence must contain the case number (except for the initial hearing request) as well as the provider or group name, the provider number (for individual appeals), and the appealed period.

3.6 Submission of Materials Involving Multiple Case Numbers

If a submission applies to multiple cases, the documents must caption all impacted cases. The Board also requires that the requisite documentation be provided for each case referenced in the document.

3.6.1 Electronic Submissions through OH CDMS

Exceptions for submissions through OH CDMS include:

- Transfers need only be submitted in the originating case. OH CDMS will automatically populate the receiving case with the corresponding information.
- Position papers and other filings specifically requested in a consolidated Notice of Hearing need only be filed in the lead case. The notice must be identified as "consolidated" and have an attached list of related cases. This does not apply to cases that are merely being concurrently scheduled for the same hearing date. OH CDMS will populate all of the cases on the related case listing with the documentation filed in response to the Notice of Hearing.

3.6.2 Hard Copy Submissions

The Board requires that enough copies be sent for **each case** referenced in the document and the respective case number must be highlighted on each copy. There are no standard exceptions for hard copy submissions. However, if the submission applies to a consolidated hearing (e.g., a consolidated final position paper or witness list), parties may check with the Board Advisor to determine if the requirement to file multiple copies may be waived on a case-by-case basis.

Rule 4 Board Jurisdiction/Appealing Issues

4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

Appeals that fail to meet the timely filing requirements or 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.

4.2 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 Appeal Period

4.3.1 Contractor Final Determination

Contractor final determinations include:

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

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

4.3.2 Federal Register Notice

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

4.3.3 Lack of Timely Contractor Determination

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

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

4.4 Due Dates

4.4.1 Due Dates for New Appeals

New appeals must be received by the Board no later than 180 days from the commencement of the appeal period as specified in Rule 4.3.

4.4.2 Due Dates for Other Filings

All other filings, including position papers and other responsive documents, must be received by the Board no later than the date specified on the Board's notice.

4.4.3 Due Date Exception When Board's Offices Are Closed

If the due date falls on a Saturday, a Sunday, a Federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days. *See* 42 C.F.R. § 405.1801(d)(3).

4.5 Date of Receipt by the Board

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

A. the date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

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

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

4.6 No Duplicate Filings

4.6.1 Same Issue from One Determination

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

4.6.2 Same Issue from Multiple Determinations

Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.

4.6.3 Issue Previously Dismissed or Withdrawn

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

4.7 Issue Location

4.7.1 General Rule

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

4.7.2 Exceptions – Board Order Must Establish Location

4.7.2.1 Requests to Join 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.)

4.7.2.2 Transfer Requests from Group Cases into Other Appeals

Once a provider has joined a group, a transfer from the group appeal will be permitted only on written motion approved by the Board. (*See* Rules 17 and 18.)

4.7.3 Issues to Be Transferred to Groups

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

Rule 5 Provider Case Representative

5.1 Persons

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

The designated case representative is the individual with whom the Board maintains contact. The case representative may be an external party (e.g., attorney or consultant) or an internal party (e.g., employee or officer of the provider or its parent organization), but there may be only one case representative per appeal. The Board will not accept an appeal or other correspondence from any external organization that is not designated as the official case representative.

5.2 Responsibilities

The representative is responsible for ensuring his or her contact information is current with the Board, including a current email address and phone number. The case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party.

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

5.3 Communications with Providers

The Board's communications will be sent to the case representative via email. The Board will address notices only to the 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 Representation Letter

A representation letter is required whether designating an external or internal representative. The letter designating the representative must be on the provider's letterhead and be signed by an authorizing official of the provider or parent organization. The letter must reflect the provider's name, number, and fiscal year under appeal. The letter must **not** be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised.

The letter must contain the following contact information for the representative:

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

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

5.5 Withdrawal of Representation

A designated representative may withdraw an appearance by filing a notice of withdrawal with the Board.

5.5.1 Deadlines Must Continue To Be Met

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

5.5.2 Provider's Consent Obtained for Withdrawal

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

5.5.3 Provider's Consent Not Obtained for Withdrawal

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

Rule 6 Filing an Individual Appeal

6.1 Initial Filing

6.1.1 Request and Supporting Documentation

To file an individual appeal, log onto OH CDMS and follow the prompts. Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation. (*See also* guidance in Rules 7 and 8). The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b).

6.1.2 Deadlines and Timeframes Relating to Initial Filing

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

6.2 Adding a New Issue to an Individual Case

6.2.1 Request and Supporting Documentation

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

- timely files a request to the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request, and

- includes all required supporting documentation as noted in Rule 7.

Log onto OH CDMS to add an issue to an existing appeal. Reference Model Form C – Request to Add Issue (Appendix C) for all required data fields and supporting documentation.

6.2.2 Deadlines and Timeframes Relating to Added Issue

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

6.3 Adding a New Determination to an Individual Case

6.3.1 Request and Supporting Documentation

For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), providers must timely request to add the subsequent determination to its pending appeal for that cost reporting period. Reference Model Form A – Individual Appeal Request (Appendix A) for all required data fields and supporting documentation.

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

6.3.2 Deadlines and Timeframes Relating to Added Determination

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

6.4 Amount in Controversy

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

6.5 Certifications

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

- I certify that none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal.
- I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a

Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).

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

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

The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

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

7.1 Final Determination

7.1.1 General Requirements

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

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

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

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

7.1.2 Additional Requirements for Specific Determination Types

7.1.2.1 Revised NPR

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

7.1.2.2 Exception Request

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

7.1.2.3 Federal Register Notice

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

7.1.2.4 Quality Reporting Payment Reduction Decision

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

7.1.2.5 Other Final Determination

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

7.2 Issue-Related Information

7.2.1 General Information

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

- An issue title and a concise issue statement describing:
    - the adjustment, including the adjustment number,
    - the controlling authority,
    - why the adjustment is incorrect,
    - how the payment should be determined differently,
    - the reimbursement effect, and
    - the basis for jurisdiction before the PRRB.
- A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
- A calculation or other support for the reimbursement effect noted in the issue statement.
- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.

7.2.2 Additional Information

Providers must submit additional information not specifically addressed above in order to support jurisdiction or appropriate claim for the appealed issue(s).

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

7.3 Self-Disallowed Items (Applies to Cost Reporting Periods Ending On or Before 12/31/15)

7.3.1 Authority Requires Disallowance

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

- a concise statement describing the self-disallowed item,
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed.

7.3.2 No Access to Data

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

7.3.3 Protest

Effective for cost reporting periods ending on or after December 31, 2008, items claimed under protest on the cost report must follow the applicable procedures as contained in CMS Pub. 15-2, Section 115. *See* 42 C.F.R. § 405.1835(a)(1)(ii).

For the appeal, you must:

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

Note: CMS Ruling 1727-R governs for cost reporting periods ending on or after 12/31/08 and beginning before 1/1/16.

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

7.4 Determination of Appropriate Claim (Applies to Cost Reporting Periods Beginning On or After 1/1/16)

If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to said appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the following procedures:

A. The Board must give the parties an adequate opportunity to submit factual evidence and legal arguments regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal.

B. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements in the regulations.

7.5 Failure to Timely Issue Final Determination

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

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

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

Rule 8 Framing Issues for Adjustments Involving Multiple Components

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. Several examples are identified below, but these are not exhaustive lists of categories or issues.

A. Disproportionate Share Hospital Payments

Common examples include: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, Section 1115 waiver days (program/waiver specific), and observation bed days.

B. Bad Debts

Common examples include: crossover bad debts, collection effort, use of collection agency, 120-day presumption, and indigence determination.

C. Graduate Medical Education/Indirect Medical Education

Common examples include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.

D. Wage Index

Common examples include: wage data corrections, occupational mix, wage vs. wage-related costs, pension, rural floor, and data corrections.

Rule 9 Board Acknowledgement of Appeals

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

The 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 proposed joint scheduling order ("PJSO") per Rule 23.2) may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

COMMENTARY:

If the case representative has not received an acknowledgement letter from the Board establishing critical due dates within 30 days following the filing of an appeal request, the 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 an email address) per Rule 5.2.

Rule 10 Medicare Contractor Response upon Filing of Individual Appeal

10.1 Duty to Confer

Once the deadline for the provider to add issues has passed (*see* Rule 6.2), it is the Medicare contractor's responsibility to:

- 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.

(*See* 42 C.F.R. § 405.1853.)

10.2 Duty to Respond to Requests

If the Medicare contractor opposes a provider's expedited judicial review request, motion for good cause extension of time 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 Intentionally Left Blank

The rule related to adding a new issue to an existing appeal is now located at Rule 6.2.

Rule 12 Filing a Group Appeal

12.1 Initial Filing

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

COMMENTARY FOR GROUP APPEALS FILED THROUGH OH CDMS:

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

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

12.2 General Requirements

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

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

12.3 Types of Groups

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

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

12.3.2 Optional Group

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

12.4 Amount in Controversy Timeframe

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

12.5 Group Cost Reporting Periods

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 minimum number of providers or the $50,000 amount in controversy requirements. Failure to provide justification for an expansion of a group to cover multiple years will result in denial of the request.

12.6 Number of Providers in Group

12.6.1 Mandatory CIRP Groups

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

12.6.2 Optional Groups

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

12.7 Optional and Mandatory Group Providers Not Combined

Providers that are not part of a CIRP 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.

12.8 Authorization for Group Representative

The Board will recognize a single group representative for all participating providers in a group. Each provider must file a representation letter in accordance with Rule 5. Providers without a representation letter will not be permitted to join the group.

12.9 Initial Selection of Lead Medicare Contractor

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

12.10 Certifications

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

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

12.11 Timeliness of Transferring Issues to a Group Appeal

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

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

Rule 13 Common Group Issue

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

13.1 Multiple Issues in Group Appeal

Upon notification from the Board that a group appeal involves more than a single common question of fact or interpretation of law, regulation or CMS policy or ruling, the group representative shall file a request for bifurcation of the group appeal within 90 days of the

notification. Failure of the group representative to timely file the request for bifurcation may result in the Board taking action per 42 C.F.R. § 405.1868.

Rule 14 Acknowledgment of Group Appeal

The group representative and the lead Medicare contractor will receive an Acknowledgement and Critical Due Dates Notice via email 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.

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, discovery and other documentation requirements. Failure by a party to comply with such deadlines may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

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

15.1 Challenging Lead Medicare Contractor Designation on Initial Filing

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

15.2 Advise Board if Group Is Proper

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

- whether the group appeal establishes a single common issue, and
- whether the parties creating the group have preserved their right to appeal and meet the jurisdictional and appeal filing requirements, except the amount in controversy need not be met until full formation of the group.

Rule 16 Requests to Join a Group Appeal

A provider may request to join an existing group by transferring the relevant issue from the provider's individual appeal to that group OR directly appealing from a final determination. When joining a group appeal through OH CDMS, follow the prompts. Reference Model Form D – Request to Transfer Issue (Appendix D) and Model Form E – Request to Directly Add Provider to Group (Appendix E) for all required data fields and supporting documentation.

16.1 Filing Requirements for Requests to Transfer from Individual Appeal

16.1.1 Transfer Requests via OH CDMS

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

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

16.1.2 Transfer Requests via Hard Copy

In addition to the information noted above, the provider is required to attach the following supporting documents to its hard copy transfer request:

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

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

16.2.1 Direct Add Requests via OH CDMS

Direct add requests submitted through OH CDMS may be initiated in conjunction with a new group appeal request or within an existing group. The request must include the same information required for a provider filing an individual appeal, including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal.

16.2.2 Direct Add Requests via Hard Copy

Direct add requests submitted in hard copy require all of the information identified in Rule 16.2.1 plus a copy of Model Form E – Request to Directly Add Provider to Group (Appendix E).

Rule 17 Transfers from Group Appeal into Other Appeals

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

Rule 18 Restructuring of Groups

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

Rule 19 Full Formation of Groups

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

19.1 Optional Groups

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

Within the Board's Acknowledgement of a CIRP group appeal, the providers are notified that at the one-year mark (if they had not previously done so) they must notify the Board if the group is complete, and if not, which providers have not yet received a final determination for the specified fiscal year.

19.3 Change of Lead Medicare Contractor upon Full Formation

19.3.1 On Motion of Group Representative

If the group representative believes that the lead Medicare contractor should be changed, the group representative must contact the current and proposed lead Medicare contractors and file a motion to change the designation of the lead Medicare contractor based upon the criteria in Rule 19.4 within 15 days of the full formation of the group. The group representative must indicate whether the Medicare contractors concur with the change and send a copy of such motion to both Medicare contractors. If the parties cannot reach agreement, the Medicare contractors may file an objection setting out their reasons and the Board will make the determination.

19.3.2 On Motion of Lead Medicare Contractor

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

19.4 Criteria for Selection of Lead Medicare Contractor

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

19.5 Joining a Group Post Full Formation

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

Rule 20 Group Schedule of Providers and Supporting Documentation – Procedure

20.1 Filing Requirements

Within 60 days of the full formation of the group (*see* Rule 19), the group representative must prepare a schedule of providers (Model Form G at Appendix G) and supporting jurisdictional documentation that demonstrates that the Board has jurisdiction over the providers named in the group appeal (*see* Rule 21).

- The schedule of providers and jurisdictional documents is to be sent to the Board.
- A copy of the schedule and all documentation is to be sent to the Lead Medicare Contractor.
- An additional copy of only the schedule of providers, without the accompanying jurisdictional documents, is to be sent to the Appeals Support Contractor.

COMMENTARY:

Although the PRRB is moving to its electronic case management system, it will take additional time to fully populate the existing participants in the group cases. Therefore, until further notice, the Board is still requiring a ***hard copy*** of the Schedule of Providers and its accompanying supporting documentation.

The Schedule of Providers will eventually be replaced by the listing of participating providers and the associated documentation provided through add requests and transfer requests made within OH CDMS.

20.2 Medicare Contractor to Initially Review Format

If the schedule and supporting documentation is not submitted in the proper format as described below, the Medicare contractor is to return the materials to the group representative within 15 days of receipt, 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 G – Schedule of Providers (Appendix G) is included to assist in this process. To this end, it is the responsibility of the group representative to gather these data elements and supporting documentation for each provider to be included in the group, even when such documentation may be on file with the Board in another appeal (e.g., the underlying individual

appeal, another group appeal). Failure to submit the requisite documentation for one of the providers may result in the dismissal of that provider from the group.

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

20.3 Format of Schedule

20.3.1 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.

20.3.2 The Schedule and Supporting Documentation Must Correspond

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

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

Rule 21 Group Schedule of Providers and Supporting Documentation – Content

The schedule of providers must include all providers in the group and provide the associated documentation to support jurisdiction of the participating providers. The schedule has two parts, a summary page with columns A-G and supporting documentation under the corresponding tabs A-G.

21.1 General Information

Enter basic information about each participating provider including the following:

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

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

21.2 Date of Final Determination

21.2.1 Schedule – Column A

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

21.2.2 Documentation – Tab A

A copy of the final determination you are appealing:

- For a NPR appeal, submit the dated NPR cover page(s). Do not submit the entire NPR.
- For a revised NPR appeal, submit the dated revised NPR cover page(s). Do not submit the entire revised NPR. *See* Rule 7.1.2.1 for additional documentation requirements for appeals filed from a revised NPR.
- For appeals of other final determinations (e.g., exception and exemption denials, Federal Register notices, Quality Reporting reconsideration denials, etc.), submit a copy of the final determination being appealed. (*See* Rules 7.1.2.2 – 7.1.2.5.)
- For appeals of the Medicare contractor's failure to timely issue an NPR, submit a copy of:
    - evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
    - evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (*See* Rule 7.5.)

21.3 Date of Hearing Request

21.3.1 Schedule – Column B

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

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

21.3.2 Documentation – Tab B

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

21.4 Number of Days

21.4.1 Schedule – Column C

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

21.4.2 Documentation – Tab C

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

21.5 Audit Adjustment Number

21.5.1 Schedule – Column D

Identify the audit adjustment or determination/authority challenged.

21.5.2 Documentation – Tab D

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

21.6 Amount in Controversy

21.6.1 Schedule – Column E

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

21.6.2 Documentation – Tab E

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

21.7 Prior Case Number(s)

21.7.1 Schedule – Column F

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

21.7.2 Documentation – Tab F

No corresponding documentation required, but see Tab G below.

21.8 Dates of Direct Add/Transfer

21.8.1 Schedule – Column G

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

21.8.2 Documentation – Tab G

The letter or Model Form transferring the issue from the individual appeal to a group appeal, as well as any subsequent transfer to a second or third group must be placed under this tab. If the cases were restructured, include a copy of the request to restructure and the Board’s letter restructuring the case. The letters should be placed under the tab in chronological order

(earliest to latest) to correspond with the schedule of providers. The dates of the letter(s) must match the dates recorded in column G of the schedule of providers. (*See* Rules 16, 17 and 18.)

21.9 Representation Letter

21.9.1 Schedule – Not applicable.

21.9.2 Documentation – Tab H

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

Rule 22 Medicare Contractor Review of Group Schedule of Providers

The lead Medicare contractor is responsible for reviewing the schedule of providers and the associated jurisdictional documentation. This review is to be completed, with written notice to the Board of the lead Medicare contractor's findings on jurisdiction, within 60 days of receipt. If minor deficiencies in documentation are identified, the Medicare contractor is encouraged to contact the group representative to provide the opportunity to cure the submission.

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

If a jurisdictional challenge is to be filed, that correspondence must be submitted separately.

PART II:
PRE-HEARING PROCEDURES

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

COMMENTARY:

The Board is continuing to offer two briefing options: (1) each party filing a preliminary position paper OR (2) the parties jointly establish the deadlines in a PJSO. The Board has made rule changes for both options as noted below.

Option 1 – Preliminary Position Papers:

In the past, the parties exchanged with each other full copies of the preliminary position paper but provided the Board only a copy of the cover sheet, listing of exhibits, and good faith statement. However, with the implementation of OH CDMS, the parties are now required to file the complete preliminary position paper with the narrative, listing of exhibits, and all exhibits. As the Board will now obtain a full copy of the preliminary position paper, which is required to have the fully developed position and identification of the controlling authority needed to support each issue in the appeal, final position papers will be optional for new appeals filed on or after the effective date of the rules. Final position papers are still mandatory for all appeals that were filed prior to that date.

Final position paper deadlines will still be established for all cases in the Notice of Hearing. For cases with optional final position paper filing requirements, parties may choose to submit a final position paper if they believe it will be useful to narrow or resolve the issues remaining in dispute, update legal authorities, etc. If the final position paper is not submitted by the deadline, the party will be limited to its initial arguments and documentation. Cases with mandatory position paper filing requirements are still subject to dismissal or other actions noted in 42 C.F.R. § 405.1868 if the final position paper is not timely filed.

Option 2 – Proposed Joint Scheduling Order:

The PJSO was implemented in 2008 to provide more flexibility in the prehearing process. In recent years, the Board has received very few PJSOs. For PJSOs filed on or after the effective date of the rules, the parties will continue to set timeframes for the exchange of documentation in order to resolve an appeal prior to the filing of a position paper. However, under the new PJSO rules, the Board will not track deadlines prior to that of the preliminary position paper. The deadlines the parties set for preliminary position papers to be exchanged if the case is not resolved will be a Board deadline, subject to 42 C.F.R. § 405.1868. The Board will set the actual hearing date and associated final position paper deadlines.

23.1 Duty to Confer

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, which is a detailed prehearing schedule (except the Board will establish final position paper due dates based on the actual hearing date, *see* Rule 27). The PJSO is based on the parties' analysis of the development needed for the case. The PJSO is subject to Board approval. (*See* Rule 24)
- If the parties do not elect the PJSO process, they must file preliminary position papers and follow the timelines established by the Board in its acknowledgement letter.

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

23.2 Proposed Joint Scheduling Order

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

23.3 Preliminary Position Papers Required if PJSO Is Not Executed

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

COMMENTARY:

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

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

23.4 Failure to Timely File

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

23.5 PJSO and Preliminary Position Paper Extension Requests

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

23.6 Miscellaneous Motions Filed Prior to PJSO or Position Paper Deadline

Pending requests (such as transfers, requests for abeyance, expedited judicial review, mediation, jurisdictional challenges, discovery, or other motions), until complete or ruled on favorably by the Board where applicable, will not suspend these filing 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.

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.

COMMENTARY:

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

Rule 24 PJSO Content and Board Acceptance

24.1 General

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

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

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

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

24.2 Format / Content of PJSO

The PJSO must address the following items:

A. Resolved Issues

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

B. Conditionally Resolved Issues

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

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

C. Unresolved Issues

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

- Identify the material facts and indicate whether they are disputed.
- If the claim cannot be resolved because of a question of law, state each party's legal position and the authorities relied on.
- Identify the documentation exchanged to date.
- If the parties expect the case to require discovery or a voluntary exchange and analysis of data, create a detailed timetable/schedule for that exchange. This

schedule will supersede the timelines in the regulations, as permitted by 42 C.F.R. § 405.1853(e)(3).

- Once the PJSO is approved by the Board, the parties may modify PJSO deadlines by joint agreement. A modification of the hearing date, preliminary position paper due dates or final position paper due dates requires Board approval and a showing of good cause. For other deadlines, it is not necessary to file modifications with the Board unless a dispute arises that requires Board action.

D. Proposed Hearing Date

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

E. Signatures

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

24.3 Board Response to PJSO

24.3.1 Issuance of Notice of Hearing

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

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

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

24.3.2 Rejection of PJSO in Whole or in Part

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

24.4 Failure to Meet PJSO Deadlines

The Board will not track deadlines prior to that of the preliminary position paper. If deadlines are missed and the parties cannot reach agreement for a modification or if you believe the other

party is not acting in good faith, contact the Board. The Board will return the case to the traditional position paper briefing track and accelerate the hearing, if necessary.

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

Rule 25 Preliminary Position Papers

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

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

25.1.2 Medicare Contractor's Responsive Position Paper

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

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

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

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

E. Identify any additional documentation required for resolution.

F. State the material facts that support the Medicare contractor adjustments.

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

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

25.1.3 Provider Response to Medicare Contractor Position Paper

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

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, 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 Board and the opposing party.

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

COMMENTARY:

Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

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

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

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

B. Numbering – Number every page of the position paper and number each page of each exhibit.

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

D. Legible Copies – Exhibits must be legible.

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

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

25.4 PJSOs Filed after the Preliminary Position Papers

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

established by the Board but will not postpone a scheduled hearing date unless approved by the Board.

Rule 26 Prehearing Discovery

26.1 No Filing of Discovery Requests/Responses Except in Disputes

The parties are expected to voluntarily exchange documents relevant to the 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 entity from whom discovery is requested and on the opposing party; it is **not** to be filed with the Board.

The deadlines for requesting discovery are established by either:

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

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

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.
- 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 or applicable nonparty must file a response to a motion to compel or motion for a protective order within 15 days from the date the motion is received.

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

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

Rule 27 Final Position Papers

27.1 General

For new appeals filed on or after the effective date of the rules, the parties will have exchanged, and the Board will have received a copy of, a full preliminary position paper setting forth the arguments and legal authorities for each issue in the appeal. Therefore, for appeals filed after the effective date of the rules, the final position paper is an optional filing, intended to hone the issue if necessary, but is not required. If no paper is submitted, the arguments related to the issues under appeal will be limited to those set forth in the preliminary position paper.

For appeals filed prior to the effective date of the rules, the final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868.

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

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. The minimum requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.

27.3 Revised or Supplemental Final Position Papers

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 Expanding Scope of Arguments in Final Position Papers Is Prohibited

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 or its own motion, exclude such arguments or evidence from consideration.

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), the witness list must 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

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

- Issues remaining

- 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 and Postponements

30.1 Notice of Hearing

The Board will issue a Notice of Hearing setting the hearing date and final position paper due dates. The hearing date established by this notice will serve as the date that governs deadlines for the optional 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.

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

30.3.1 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. 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.

30.3.2 Request Content

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

- The reason the parties are not ready for hearing.
- An explanation (include dates and events) how the parties have worked together to settle or narrow the issues.
- List the actions needed to be ready for hearing.
- Whether both parties concur with the postponement request.
- A proposed month and year in which to reschedule the case.

30.3.3 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.

30.4 Consolidated Hearings

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

Rule 31 Accelerated Hearing Date

31.1 Request

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 shall demonstrate that the case has no impediments to a hearing (such as outstanding motions or discovery requests) and the 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 1508 Woodlawn Drive, Suite 100, Baltimore, MD 21207.

32.2 Telephone Hearing

The parties may request to present all or part (e.g., witness testimony) of their case by telephone. Generally, an appropriate case to hear in its entirety by telephone would involve a

strictly legal issue, or a case with few disputed material facts and witnesses that would require minimal reference to exhibits. A telephone hearing should not exceed 2 hours.

Remote 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 both parties' organized and labeled exhibits available for reference.

32.3 Video Hearing

The Board anticipates being able to hold video hearings where parties may request to present all or part of their case via video conferencing. Similar to a telephone hearing, a video hearing should be limited to those cases that involve a strictly legal issue, or a case with few disputed material facts and witnesses that would requires minimal reference to exhibits.

32.4 Record Hearing

In cases involving only legal interpretation or very limited fact disputes, and where both parties agree that the case is appropriate for a record hearing, the Board may approve the parties' request to submit their case only on the existing written record. Generally, record hearings are inappropriate when material facts are 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.

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

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

Rule 33 Conduct of Hearing

33.1 General

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

33.2 Sequence

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

33.3 Opening Statements

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

33.4 Witness Examinations

33.4.1 Availability

Any person present in the hearing room or via telephone or video conference is subject to being called as a witness without a subpoena. 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.

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

33.4.2 Order of Questioning

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

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

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

33.4.3 Direct Examination

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

33.4.4 Cross Examination

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

33.4.5 Rebuttal Witnesses

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

33.5 Closing Arguments

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

33.6 Adjournment of Hearing

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

Rule 34 Expert Witnesses

34.1 Expert Witness Defined

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

34.2 Expert Qualification

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

34.3 Expert Report

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

Rule 35 Hearing Materials

35.1 Board Copies of Position Paper

The parties are to furnish **6** additional copies of the latest filed position paper (and the revised or supplemental final position papers, if applicable) and attach the hearing exhibits. **Do not submit the Board members' copies at the time of filing the preliminary or final position paper.** The Board copies must be received at the Board 10 days before the hearing. Board members' copies should be designed for easy reference during the hearing and may be in loose-leaf binders but must otherwise meet all of the same requirements as for the original filing. Please notify your assigned Board Advisor when you send the copies.

35.2 Stipulations

35.2.1 General

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

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

35.2.2 Procedure

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

35.3 Documentary Evidence

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

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

35.4 Visual Aids

35.4.1 Prepared Prior to the Hearing

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

35.4.2 Creation of Visual Aids During a Hearing

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

35.5 Summaries

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.

35.6 Deposition Testimony and Interrogatories

Deposition testimony may be used at the hearings as if the deponent(s) were present and testifying. At least 10 days before the hearing, the party proposing to use deposition testimony must notify the opposing party and specify the pages and lines to be read. The opposing party may require the party offering deposition testimony to include additional excerpts from the

deposition. Prior notice is unnecessary if the testifying witness is present and the deposition testimony is used for rebuttal or impeachment. Interrogatory responses may be used without prior notice.

35.7 Affidavits

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

35.8 Prior 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.

35.9 Transcript

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

Rule 36 Post-Hearing Submissions

36.1 General

Post-hearing briefs may only be submitted if requested by the Board at the close of the hearing. If requested, the Board will set the deadlines for the submission of post hearing briefs and the parties must submit a copy for the record and **6** additional hard copies of their submissions for the Board.

36.2 Post-Hearing Submissions

36.2.1 Evidence

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

36.2.2 Briefs

If requested by the Board, post-hearing briefs should be similar to the closing argument (*See* Rule 33.5) in that the post hearing brief should cite the key testimonial and documentary

evidence presented, and apply the controlling legal authority. The brief should contain citations to the transcript and the exhibits where appropriate. A post-hearing brief should not contain new information or evidence (*see* Rule 33.6) unless authorized by the Board. Additional authorities or summaries of the evidence presented are appropriate, however.

Rule 37 Board Decision

The Board decision is final and binding upon all parties to the hearing except as provided in 42 C.F.R. § 405.1871(b). Board decisions are available on the Board's website at http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/List-of-PRRB-Decisions.html.

Rule 38 Quorum of the Board

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

PART IV:
OTHER GENERAL RULES

Rule 39 Abeyance Requests

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

The 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.

The parties are required to notify the Board upon the resolution of the pending case or a change in the specified conditions or events that led to the abeyance.

Rule 40 Contact with the Board Staff

40.1 Do Not Directly Contact Board Members

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

40.2 Ex Parte Communications

40.2.1 Procedural Matters

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

40.2.2 Substantive Matters

It is improper to communicate with the Board or its staff concerning the merits of a case pending before the Board unless all parties are included in the communication. All communications from

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

Rule 41 Dismissal or Closure

41.1 Parties' Motion

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

41.2 Own Motion

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

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

Rule 42 Expedited Judicial Review

42.1 General

A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. In an appeal containing multiple issues, EJR may be granted for fewer than all the issues, in which case the Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days after it determines 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.

42.3 Content of the EJR 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,
- demonstrates that the Board has jurisdiction,
- identifies the controlling law, regulation, or CMS ruling, and
- explains why the Board does not have authority to decide the legal question.

For a group appeal, the schedule of providers and supporting jurisdictional documents for each provider must also be filed in accordance with Rules 20 and 21. If the jurisdictional documents are not tabbed and formatted in accordance with the Board's instructions, the Board will return them to the group representative for correction before considering the EJR request.

Rule 43 Mediation

43.1 General

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

43.2 Requesting Mediation

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

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

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

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

43.3 Scheduling a Mediation Session

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

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

43.4 Participating in a Mediation Session

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

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

Rule 44 Motions

44.1 In Writing

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

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

44.3 Time for Filing Response

Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 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.

44.4.1 Individual Cases

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

44.4.2 Group Cases

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

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

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

44.4.3 Provider Responses

Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

COMMENTARY:

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

Rule 45 Recusal of Board Members

45.1 General/On Own Motion

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

45.2 Party May Request Recusal

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

45.3 Recused Board Members

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

Rule 46 Withdrawal of an Appeal or Issue within an Appeal

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 Medicare contractor has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Medicare contractor where the Medicare contractor agreed to that reopening; (4) all issues in a case where the provider intends to pursue reopening simultaneously with the appeal request (*see* Rule 47.2.3); and (5) 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 Medicare contractor's action through an administrative resolution or reopening; and (3) confirm whether there are any other issues remaining in the case and, if so, provide the status on each remaining issue. Note 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.

Rule 47 Reinstatement

47.1 Motion for Reinstatement

A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rule 47.2 below.

47.2 Reinstatement Requests Subsequent to Withdrawal

47.2.1 Administrative Resolution

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

47.2.2 Medicare Contractor Agreement to Reopen

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

47.2.3 Requests to Pursue Reopening Simultaneous to Appeal Filing

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

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

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

47.3 Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement

negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.

Rule 48 Subpoenas

48.1 Only the Board Can Issue a Subpoena

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

- be submitted through OH CDMS or 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.
- The subpoena request must include the contact information (name and address) of the person to be subpoenaed or the location of the documents to be obtained along with the contact information for the custodian of the documents. The Board handles the service of the subpoena.

48.2 Response

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

Rule 49 Intentionally Left Blank

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

50.1 General

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

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

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

50.2 Process for Filing a CHGME Appeal

50.2.1 Time for Filing

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

50.2.2 Where to File

Appeals may be filed electronically through OH CDMS. *See* Rule 2 and https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html.

If filing manually, submit to:

Provider Reimbursement Review Board
ATTN: PRIORITY CHGME
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207

50.2.3 Telephone Notice to Board

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

50.2.4 No Supporting Documentation to Board with Initial Filing

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

50.2.5 Other Parties to Receive Notice of Appeal and Supporting Documents

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 ("OGC") 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 to the Board must contain the information and documents listed below.

A. Contact Information

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

B. Final Determination Information

1. Fiscal year end of the cost report from which the FTE count was reviewed
2. A copy of the "CHGME Program Payment Assessment of Full-Time Equivalent Resident Count"

C. Issue Information

1. Issue title(s) and a complete statement of the issue(s) under appeal
2. Identification of the relevant audit adjustments and a copy of the associated audit adjustment report pages
3. Identification of the amount in controversy and supporting calculation of that amount

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 the rules outlined in this document. The Board will set the time for response in the Acknowledgement.

50.7 Extensions/Postponements

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

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

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

Select the type of appeal request.

☐ **Initial Individual Appeal Request**

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

or

☐ **Supplemental Appeal from Additional Final Determination**

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

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

General Information

Provider Information

Provider Number: _____

Provider Name: _____

Street Address: _____

City, State and ZIP: _____

MAC Information

MAC Code: _____

MAC Name: _____

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

Representative Information

Name: _____

Title: _____

Organization: _____

Address: _____

City, State and ZIP: _____

Telephone Number: _____

E-mail Address: _____

Attach Representation Letter.

Determination Information

Select the type of final determination being appealed.

- ☐ **Notice of Program Reimbursement**
- ☐ **Revised NPR**
- ☐ **Exception Determination**
- ☐ **Federal Register Notice**
- ☐ **Failure to Issue a Timely Determination**
- ☐ **Quality Reporting Payment Reduction**
- ☐ **Other**

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

Determination Support:
Notice of Program Reimbursement

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

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

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

Attach Proof of Receipt.

Determination Support:
Revised NPR

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

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

Attach the Reopening Notice issued by the MAC.

Prior NPR Issuance Dates:

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

_____ _____ _____ _____

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

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

Attach Proof of Receipt.

Determination Support:
Exception Determination

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Exception: _____

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

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

Attach Proof of Receipt.

Determination Support:
Federal Register Notice

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Federal Register Citation: _____

Determination Support:
Failure to Issue a Timely Determination

Fiscal Year End Date: _____

MAC Receipt Date of Filed Cost Report: _____

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

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

Determination Support:
Quality Reporting Payment Reduction

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Quality Reporting Program: _____

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

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

Attach Proof of Receipt.

Determination Support:
Other

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Other Final Determination: _____

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

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

Attach Proof of Receipt.

Appeal Issues

Complete this page for each issue being appealed.

Issue-Related Information

Issue Number: _____

Issue Title: _____

Attach Issue Statement.

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

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

Certifications

Check each box to accept the following certification statements.

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

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

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

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

Signature: _____

Printed Name: _____

Date: _____

Appendix B:
Model Form B – Group Appeal Request

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

General Information

Select the type of group.

☐ **Optional Group**

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

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

Parent Information

(Applicable to CIRP groups only)

Parent Organization: _____

Street Address: _____

City, State and ZIP: _____

Representative Information

Name: _____

Title: _____

Organization: _____

Address: _____

City, State and ZIP: _____

Telephone Number: _____

E-mail Address: _____

Issue Information

Issue Title: _____

Attach Issue Statement.

Is this appeal based on a Federal Register Notice? _____

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

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

Lead MAC Information

MAC Code: _____

MAC Name: _____

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

Group Participants

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

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

Attach Representation Letters for each provider.

Certifications

Check each box to accept the following certification statements.

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

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

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

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

Signature: _____

Printed Name: _____

Date: _____

Appendix C:
Model Form C – Request to Add Issue

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

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

Case Number: _____

Case Name: _____

Issue-Related Information

Final Determination Type: _____

Date of Final Determination under Appeal: _____

Issue Title: _____

Attach Issue Statement.

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

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

Certifications

Check each box to accept the following certification statements.

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

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

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

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

Signature: _____

Printed Name: _____

Date: _____

Appendix D:
Model Form D – Request to Transfer Issue

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

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

Individual Case Number: _____

Individual Case Name: _____

Transfer Information

Group Case Number: _____

Group Case Name: _____

Attach Representation Letter for group appeal.

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

Determination Information

Final Determination Type: _____

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

MAC Code: _____

MAC Name: _____

Issue-Related Information

Issue Title: _____

Was this issue protested on the filed cost report? _____

Audit Adjustment Number: _____

Amount in Controversy: _____

Certifications

Check each box to accept the following certification statements.

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

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

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

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

Signature: _____

Printed Name: _____

Date: _____

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

All appeal requests and subsequent correspondence may be filed through the Office of Hearings Case and Document Management System. *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Electronic-Filing.html. The Board strongly encourages the use of OH CDMS, but model forms are available for reference purposes.

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

Group Case Number: _____

Group Case Name: _____

General Information

Provider Information

Provider Number: _____

Provider Name: _____

Street Address: _____

City, State and ZIP: _____

MAC Information

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

MAC Code: _____

MAC Name: _____

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

Representative Information

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

Attach Representation Letter for participation in group appeal.

Issue-Related Information

Issue Title: _____

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

Was this issue protested on the filed cost report? _____

Attach Protested Item Support.

Audit Adjustment Number: _____

Attach Audit Adjustment Support.

Amount in Controversy: _____

Attach Calculation Support.

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

Determination Information

Select the type of final determination being appealed.

- ☐ **Notice of Program Reimbursement**
- ☐ **Revised NPR**
- ☐ **Exception Determination**
- ☐ **Federal Register Notice**
- ☐ **Failure to Issue a Timely Determination**
- ☐ **Quality Reporting Payment Reduction**
- ☐ **Other**

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

Determination Support:
Notice of Program Reimbursement

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

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

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

Attach Proof of Receipt.

Determination Support:
Revised NPR

Fiscal Year End Date: _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

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

Attach the Reopening Notice issued by the MAC.

Prior NPR Issuance Dates:

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

_____ _____ _____ _____

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

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

Attach Proof of Receipt.

Determination Support:
Exception Determination

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Exception: _____

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

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

Attach Proof of Receipt.

Determination Support:
Federal Register Notice

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Federal Register Citation: _____

Determination Support:
Failure to Issue a Timely Determination

Fiscal Year End Date: _____

MAC Receipt Date of Filed Cost Report: _____

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

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

Determination Support:
Quality Reporting Payment Reduction

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Quality Reporting Program: _____

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

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

Attach Proof of Receipt.

Determination Support:
Other

Select the appealed period and enter associated data.

☐ **Cost Reporting Period**

Fiscal Year End Date: _____

☐ **Federal Fiscal Year End**

Federal Fiscal Year: _____

Affected Cost Reporting Periods: _____ _____

☐ **Other**

From: _____ **To:** _____

Affected Cost Reporting Periods: _____ _____

Date of Final Determination under Appeal: _____

Attach the Final Determination.

Type of Other Final Determination: _____

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

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

Attach Proof of Receipt.

Certifications

Check each box to accept the following certification statements.

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

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

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

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

Signature: _____

Printed Name: _____

Date: _____

Appendix F:
Intentionally Left Blank

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

Appendix G:
Model Form G – Schedule of Providers

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

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

Group Representative: _____

Lead MAC Name/Code: _____

Issue Title: _____

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

Appendix H: Acronyms

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

Table 1: Acronyms

Appendix I: Record of Changes

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

Version Number	Effective Date	Description of Change
1.0	08/21/2008	Issued Rules in conjunction with new appeal regulations for Medicare Part A Provider Reimbursement Determinations and Appeals. These regulations at 42 C.F.R. § 405, Subpart R, affected all PRRB appeals pending as of, or filed on or after the effective date of the rules. *See* Fed. Reg. 30190 (May 23, 2008)
1.1	07/01/2009	Revised Rules 3, 4, 24 and 41; updated content of proposed joint scheduling order (Model Form F); and modified model forms to fillable pdf format. *See* PRRB Alert 5.
1.2	03/01/2013	Revised Rules 3, 4, 5, 7, 9, 11, 12, 14, 15, 16, 20, 21, 22, 24, 27, 30, 37, and 44; and updated model forms to incorporate changes to the Rules. *See* PRRB Alert 9.
1.3	07/01/2015	Revised Rules 46 and 48 regarding reinstatements and withdrawals at. *See* PRRB Alert 11.
2.0	08/29/2018	Revised Rules to address changes in the Board's policies and procedures and for the implementation of the Board's electronic filing system (OH CDMS). *See* PRRB Alerts 14 and 15.

Table 2: Record of Changes