PROVIDER REIMBURSEMENT REVIEW BOARD RULES

The Provider Reimbursement Review Board's (Board) Rules, which are effective August 21, 2008, are attached. To coincide with the CMS Final Rule at 73 Fed. Reg. 30190 which updated, clarified and revised regulatory provisions governing Board appeals, the attached Board Rules apply to all appeals pending as of, or filed on or after, August 21, 2008.

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

ALERTS: PLEASE SEE ALERTS ON THIS WEBSITE REGARDING TRANSITIONAL ISSUES

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

Rule 1 Overview

1.1 - Authority

These Rules govern proceedings before the Provider Reimbursement Review Board ("PRRB" or "Board"). The Rules are consistent with Section 1878 of the Social Security Act, 42 USC 1395oo and 42 CFR §§ 405.1835 – 405.1889. The Board has discretion to take action as outlined in 42 CFR §405.1868 if a party fails to comply with these rules or fails to comply with a Board order. While these instructions cite regulatory cross-references as a guide, the omission of a cross-reference does not excuse the parties from meeting all controlling statutory and regulatory requirements.

1.2 - Model Forms

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

1.3 - References to Intermediary Includes Medicare Administrative Contractor (Intermediary)

1.4 - Rules Apply to Individual and Group Appeals

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

Rule 2 - Good Faith Expectations

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

Rule 3 - Correspondence Requirements

3.1 - PRRB Mailing Address

All documents must be addressed as follows:

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

3.2 - Delivery of Materials to the Board

To meet filing deadlines, documents must be mailed via the United States Postal Service or delivered by a commercial carrier.

3.3 - Service on Opposing Parties

Copies of any document filed with the Board must simultaneously be sent to the opposing party in the same manner that it is sent to the Board.

3.4 - No Multiple Copies to Board and Staff

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

3.5 - Caption and Case Number on All Submissions

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

3.6 - Submissions of Materials Involving Multiple Case Numbers

If a submission applies to multiple cases, send a copy for each case number referenced.

Rule 4 - Board Jurisdiction/Appealing Issues

4.1 - General Requirements

See 42 CFR §§405.1835 - 405.1840.

4.2 - Parties to the Appeal

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

4.3 - Date of Receipt Presumption/Calculating Filing Deadlines

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

The date of filing with the Board is the date the Board receives it. See 42 CFR §405.1801(a)(2).

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

4.4 - Dismissal for Lack of Jurisdiction

Appeals that fail to meet the jurisdictional requirements will be dismissed. A jurisdictional challenge may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

4.5 - No Duplicate Filings

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

4.6 - Issue Location

A. General Rule

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

B. Exceptions- Board Order Establishes Location

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

2. Transfer requests from Group Cases into other appeals: Once a Provider has joined a group, a transfer will be permitted only on written motion approved by the Board. See Rules 17.3.

4.7 - Dismissed or Withdrawn Issues

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

Rule 5 - Provider Case Representative

5.1 - Persons

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

5.2 - Responsibilities

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

5.3 - Communications with Providers

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

5.4 - Designation of Representative Letter

The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. It must also contain the following contact information: name, organization, address, telephone number, fax number and e-mail address of the representative.

5.5 - Withdrawal of Representation

A. Deadlines Must Continue to be Met

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

B. Provider's Consent Obtained

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

C. Provider's Consent Not Obtained

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

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

6.1 - General- Content and Supporting Documentation

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

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

For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), timely separate appeal requests must be filed

for each subsequent final determination. When filing a subsequent appeal request for the same cost reporting period, identify the case number of the existing individual appeal.

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

6.3 - Amount in Controversy Calculations/Support (42 CFR §§405.1835 and 405.1839)

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

6.4 - Certifications

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

Rule 7 - Issue Statement and Claim of Dissatisfaction

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

7.1 - NPR or Revised NPR Adjustments

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

B. **No Access to Data**: If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

7.2 - Self-Disallowed Items

A. Authority Requires Disallowance

If you claim that the item you are appealing 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,

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

B. No Access to Data

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

C. Protest

For cost reporting periods ending on or after December 31, 2008, demonstrate how the Provider followed applicable procedures for filing a cost report under protest 42 CFR §405.1835(a)(1)(ii).

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

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

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

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

7.4 - Failure to Timely Issue Final Determination

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

- the date you filed the cost report, and
- the circumstances to show that the delay was not the Provider's fault.

Rule 8 - Framing Issues for Adjustments Involving Multiple Components

8.1 - General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate

issue and described as narrowly as possible using the applicable format outlined in Rule 7. See common examples below.

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

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

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

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

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

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

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

Rule 10 - Intermediary Response Upon Filing of Individual Appeal (See 42 CFR §405.1853)

10.1 - Duty to Confer

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

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

10.2 - Duty to Respond to Requests

If the Intermediary opposes a Provider's EJR request, motion for good cause extension of time limit for requesting a Board hearing, mediation request, or any other request, its response must be timely filed in accordance with Rules 42, 43, and 44.

Rule 11 - Adding a New Issue to an Individual Case

11.1 - General - Request and Documentation

Subject to the provisions of 42 CFR §405.1835(c), an issue may be added to an individual appeal by:

A. timely filing a Model Form C (see Appendix), and

B. including all supporting documentation listed on such request.

11.2 - Deadlines and Timeframes Relating to Added Issue

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

11.3 - No Board Acknowledgement of Added Issue

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

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

12.1 - General – Form and Documentation

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

12.2 - Group Cost Reporting Periods

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

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

12.3 - Amount in Controversy Timeframe: The $50,000 threshold must be met by the full formation of the group. (See Rule 19)

12.4 - Authorization for Group Representative (See Rule 5):

A. General Rule.

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

B. Exception for transfers.

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

12.5 - Number of Providers in Group

A. Optional Group Appeals.

At least two different Providers are required to initially form an optional group. The Board may limit the number of Providers in an optional group appeal, or divide existing optional groups into various case numbers, as it deems necessary to ensure efficient case management. The Board may request the parties' input prior to limiting or dividing a case.

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

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

12.6 - **Optional and Mandatory Group Providers Not Combined**.

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

12.7 - Initial Selection of Lead Intermediary

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

Rule 13 - Common Group Issue

The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific Provider(s) may be presented as representative of all group members. Refer to Rules 7 and 8 for guidance.

Rule 14 - Acknowledgment of Group Appeal

The group representative and the lead Intermediary selected by the group representative will receive an acknowledgment from the Board indicating that the group appeal has been received and the case number assigned. If your appeal does not comply with the filing requirements, the Board may dismiss your 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, the Schedule of Providers (See Appendix - Model Form G), discovery and other documentation requirements. Failure by a party to comply with such deadlines may result in the Board taking any of the actions described in 42 CFR §405.1868.

Rule 15 - Intermediary's Responsibilities upon Receipt of Group Appeal

15.1 - Challenging Lead Intermediary Designation on Initial Filing

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

15.2 - Advise Board if Group is Proper

Within 30 days of receipt of the Board's acknowledgment of the group, the designated lead Intermediary (See Rule 12.7) must advise the Board, in writing, of its position as to the following:

A. whether the group appeal establishes a single common issue, and
B. whether the parties creating the group have preserved their right to appeal and meet jurisdictional requirements except the amount in controversy

15.3 - Duty to Respond to Requests Filed with the Appeal

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

Rule 16 - Requests to Join an Existing Group Directly from a Final Determination or Via Transfer from an Individual Appeal

16.1 - Filing: Providers may request to join an existing group via transfer or by directly appealing from a final determination (See Appendix - Model Forms D and E).

16.2 - No Acknowledgement: The Board will not acknowledge joinder to an existing group appeal prior to its being fully formed. It is your responsibility to maintain evidence of timely filing. Exception: if the appeal is fully formed, a joinder request will not add the Provider to the group unless the Board grants written approval. (See Rules 4.6.B.1, and 17.3).

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

The Board will not grant a request to transfer from a group case to another case except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation or common issue requirements. The motion must also include fully executed Model Form D (Transfer Form) and Model Form A as appropriate. No transfer from a group to another case is effective unless the transfer request is approved by the Board.

Rule 18 - Restructuring of Groups

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

Rule 19 - Completion of Groups (Full Formation) (42 CFR §405.1837(e))

19.1. - Optional Groups

A. Deadlines

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

B. Closure

The group is fully formed upon the earlier of

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

19.2. - Mandatory (CIRP) Groups

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

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

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

A. On Motion of Group Representative

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

B. On Motion of Lead Intermediary

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

19.4 - Criteria for Selection of Lead Intermediary

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

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

19.5 - Joining a Group Post Full Formation 42 CFR §405.1837(e)(4)

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

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

20.1 - Filing Requirements

Within 60 days of the full formation of the group (See Rule 19), the group representative must send a Schedule of Providers (Appendix – Model Form G) and supporting documentation (see Rule 21) with a cover letter to the lead Intermediary which demonstrates that the Board has jurisdiction over the Providers named in the group appeal. The group representative must send a copy of the Schedule of Providers and the cover letter (but not the supporting documentation) to the Board.

20.2 - Intermediary to Initially Review Format

If the Schedule and supporting documentation is not submitted in the proper format as described below, within 15 days of receipt the Intermediary is to return the materials to the group representative, along with a cover letter (with a copy to the Board) describing the formatting deficiencies (See 20.3 below).

COMMENTARY: The Schedule of Providers is designed to assemble various elements of data to demonstrate that the Board has jurisdiction over each Provider. Because some groups include numerous, even hundreds, of providers, format is essential to manage the data. The Model Form is included to assist in this process. It is unnecessary for the Intermediary to comment at this point on whether jurisdictional problems exist for any given Provider or to identify every potential default in documentation.

20.3 - Format (Appendix – Model Form G)

A. Documents Must Be Bound.

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

B. The Schedules and Supporting Documentation Must Correspond (Appendix – Model Form G)

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

Example:

Exhibit 1A will correspond to line 1, column A and will contain a copy of the final determination for the first Provider). Exhibit 2A will correspond to line 2, column A, and will contain a copy of the final determination (for the second Provider). Exhibit 1B will correspond to line 1, column B and will contain a copy of the initial Form in which this issue was appealed for the first Provider. Exhibit 2B will correspond to line 2, column B and will contain a copy of the initial Form in which this issue was appealed for the second Provider.

Rule 21 - Contents of Group Schedule of Providers and Supporting Documentation.

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

A. Date of Final Determination

1. Schedule- **Column A -** List date of final determination

2. Supporting Documentation- **Tab A** - A copy of the final determination you are appealing:

   NPR appeal: The dated NPR page. Do not submit the entire NPR.

   RNPR appeal: The dated RNPR cover pages

   Exception and exemption denials or other final determinations: A copy of all CMS and/or INTERMEDIARY final determinations as well as any relevant recommendations from the INTERMEDIARY to CMS.

   Failure to timely issue an NPR: A copy of the first page of the cost report, the certification page, and any other evidence to support the date the cost report was filed.

B. Date of Hearing Request

1. Schedule- **Column B** - Enter the date on which the hearing request for the applicable issue was filed with the Board (See Rule 4.3).

2. Documentation- **Tab B** - A copy of the relevant pages from the initial appeal request (Model Forms A, B, C or D or other written requests filed prior to the use of such Model Forms) in which this issue was appealed for the first time.

   a. If the issue was originally filed through a Model Form A or B (or other written request), also attach the form or other request including the issue statement.

   b. Attach copies of proof of receipt for all requests if available. Do not file the previously filed attachments except as requested in a. above.

C. Number of Days

1. Schedule- **Column C** - Calculate the number of days between the issuance of the final determination at issue (without the 5-day presumption in 42 CFR §405.1801) and the date the hearing request for the issue was filed.

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 CFR §405.1801(d)(3).

D. Audit Adjustment Number

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

2. Documentation- **Tab D**

a. Provide a copy of the matter appealed (i.e audit adjustment or other final determination; associated reopening requests and reopening notices.)

b. Self Disallowed Items: If the Provider is appealing this claim as a self disallowed cost, submit a brief narrative identifying the authority that the Provider is challenging, and a copy of the cost report protested item page, if applicable. For cost reporting periods that end on or after December 31, 2008, the Provider must submit the evidence of protest. (See 42 CFR §405.1835(a)(1)(ii)).

E. Amount in Controversy

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

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

F. Original Case Number (if applicable)

1. Schedule- **Column F** - If the issue was originally filed in another case, also list such case number.

2. No corresponding documentation required.

G. Dates of Add/Transfer (if applicable)

1. Schedule- **Column G** - Identify the case number that issue was added or transferred from and the date the request was received by Board.

2. Documentation - **Tab G** - Model Form D or E without supporting documentation (or other written request).

Rule 22 - Intermediary Review of Group Schedule of Providers

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

The lead Intermediary must forward the final Schedule of Providers with the documentation to the Board to become part of the official record along with a cover letter verifying its position that the issue is suitable for a group appeal (See Rule 15) and whether jurisdictional impediments exist. See Rule 10.1 for the content and format of the Intermediary's response when a jurisdiction challenge is raised.

PART II: PRE-HEARING PROCEDURES

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

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

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

23.1 - General.

The regulations give the Board broad authority and flexibility to establish procedures. The regulations at 42 CFR §405.1853 direct the parties to expeditiously join to resolve issues and reach stipulations. To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:

- jointly agree to a proposed Joint Scheduling Order (JSO), a detailed prehearing schedule (except final position paper due dates which will be based on the hearing date, see Rule 27). The JSO is based on the parties analysis of the development needed for their case or,
- If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.

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

23.2 - Proposed Joint Scheduling Order

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

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

If, for any reason, the parties do not jointly execute and file a proposed JSO by the due date, deadlines established in the Acknowledgement Letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

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

23.4 - Failure to Timely File.

The Provider's preliminary position paper due date will be set on the same day as the proposed JSO due date; accordingly, if neither a proposed JSO nor the Provider's preliminary position paper is filed by such date, the case will be dismissed. If the Intermediary fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 CFR §405.1868.

23.5 - Proposed JSO and Preliminary Position Paper Extension Requests.

Requests for extensions for filing a proposed JSO or the Provider's preliminary position papers must be filed at least three weeks before the due date and will be granted only for good cause. If the Board has not notified the moving party before the due date that an extension is granted, and a proposed JSO or position paper is not timely filed, the appeal will be dismissed.

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

Rule 24 - Proposed JSO Content/ Board Acceptance

24.1 - Format/Content

The proposed JSO must include the following (See Model Form F):

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

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

1. Provide a brief statement of the issue.

2. Describe the conditions on which resolution is based, including dates, actions, and audit methodologies required by the parties.

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

C. Unresolved Issues: For each claim not resolved,

1. Provide a brief statement of the issue.

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

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

4. Identify the documentation exchanged to date.

5. If the parties expect the case to require discovery or a voluntary exchange and analysis of data, create a detailed timetable/schedule for that exchange. This schedule will supersede the timelines in the regulations as permitted by 42 CFR §405.1853(e)(3).

6. Once the JSO is approved by the Board, the parties may modify JSO deadlines only by their signed, written agreement. An email confirmation or faxed signature is sufficient to signify agreement. A modification of the hearing date or final position paper due dates requires Board approval and a showing of good cause. For other deadlines, it is not necessary to file modifications with the Board unless a dispute arises that requires Board action. The Board will consider the agreed upon dates as deadlines and failure to meet the deadlines, upon objection, may result in Board action subject to 42 CFR §405.1868, including, but not limited to, exclusion of evidence or dismissal.

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

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

24.2 - Proposed Hearing Date

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

24.3 - Acceptance of Proposed JSO

The Board will issue a Notice of Hearing setting the hearing date and final position paper dates. The issuance of a hearing date on or after the requested hearing date will constitute acceptance of all other PJSO deadlines. All other deadlines will be controlled by the parties' JSO unless the Board advises otherwise. The parties must meet all deadlines, including agreed written modifications.

24.4 - Failure to Meet JSO Deadlines

Upon written motion (see Rule 44), the Board may exclude evidence, dismiss the case, or take other appropriate action for failure to meet the deadlines of the JSO, including deadlines modified by written agreement. (See 42 CFR §405.1868)

Rule 25 - Preliminary Position Papers

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

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

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

A. Provider's Preliminary Position Paper:

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

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

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

B. Intermediary's Responsive Preliminary Position Paper:

1. identify any jurisdictional challenges not previously raised.

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

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

4. state the basis for the disputed facts and legal principles,

5. identify any additional documentation required for resolution

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

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

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

C. Provider Response to Intermediary Preliminary Position Paper.

a. Address rebuttal or Intermediary arguments not previously addressed

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

25.2 - Preliminary Documents:

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

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

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

25.3. - Filing Requirements to Board

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

25.4 - Joint Scheduling Orders Filed after the Preliminary Position Papers

If the parties initially filed preliminary position papers instead of a proposed JSO (see Rule 23), they may nevertheless file a proposed JSO after the preliminary position papers are filed. Generally, such JSOs will supersede the rules establishing other discovery/documentation exchange deadlines established by the Board or these rules but will not postpone a scheduled hearing date unless approved by the Board. Failure to meet the agreed discovery/documentation exchange deadlines of the proposed JSO may, upon written motion, lead to the exclusion of evidence or other sanctions (See 42 CFR §405.1868)

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

Rule 26 - Prehearing Discovery

26.1 - No Filing of Discovery Requests/Responses Except In Disputes

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

26.2 - Initial Discovery Request

- The party requesting discovery must file a written request for discovery with the person from whom discovery is requested and on the opposing party; it is NOT filed with the Board.

The deadlines for requesting discovery are established by either:

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

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

- the date the request was served. The date the request was sent should be verifiable (e.g., overnight mail service tracking information for each individual notified of the request),
- the identity of each individual receiving a copy of the request, including their address, and
- signature of the representative of record and the date signed.

26.3 - Motions to Compel Discovery or for Protective Orders

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

- A copy of the discovery request. If only parts of the request are in dispute, excerpts plus the signature page and cover page to indicate the source of the excerpt may be sufficient.
- A copy of the disputed response, if any.
- An explanation for the need for relief and the legal basis.
- A declaration by the party requesting relief that he/she has conferred with the opposing party to discuss the efforts to resolve or narrow the discovery dispute. Documents reflecting these attempts may be attached.

26.4 - Response

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

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

Generally, evidence elicited through discovery may be designated as an exhibit or read into the record of the hearing. If the discovery is to be used at the hearing as evidence or is attached to the position paper as an exhibit, submit those portions relevant to the issue plus the signature page and cover page to indicate the source of the excerpt. The opposing party may submit other portions of the same document in rebuttal. Discovery may be used at the hearing for impeachment without prior notice or designation provided the entire document is available at the hearing. See Rule 35.5 for use of deposition testimony at a hearing.

Rule 27 - Final Position Papers

27.1 - General

The final position paper should reflect the refinement of the issues from the preliminary position paper or proposed JSO. The Board will set due dates for the final position papers in its Notice of Hearing, generally 90 days before the scheduled hearing date for the Provider; 60 days for the

Intermediary and 30 days for Provider response (optional). Failure to timely file the position papers may result in dismissal of the case, or any of the actions under 42 CFR §405.1868.

Exception: If, shortly before the position paper deadline, a Provider files a withdrawal request, or the parties file a fully executed Administrative Resolution withdrawing the case, and the Board has not yet officially closed the case, the parties are not expected to file final position papers.

27.2 - Content

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

a. Identification of each issue and its reimbursement impact.

b. Procedural history of the dispute.

c. A statement of facts that:

   i. Indicates which facts are undisputed.

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

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

27.3 - Revised or Supplemental Final Position Papers

Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence. However, the Board encourages revised or supplemental final position papers which, for administrative efficiency, further <u>narrow</u> 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 or reserve such rebuttal for hearing.

27.4 - Arguments Expanding the Scope of Final Position Papers

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

27.5 - Hearing Exhibits Attached to the Final Position Paper

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

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

A. **Size:** Use 8 ½ x 11 paper.

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

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

D. **Legible Copies:** Exhibits must be legible.

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

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

G. Number of Copies and Time for Filing :

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

2. Board Member Copies: The parties are to furnish 5 additional copies of the previously filed final position paper (and/or the revised or supplemental final position papers) and attach the hearing exhibits. Do not submit the Board members' copies at the time of filing the final position paper. The Board copies must be received at the Board 3-5 business days before the hearing. Board members' copies should be designed for easy reference during the hearing and may be in loose- leaf binders but must otherwise meet all of the same requirements as for the original filing. Please notify your assigned Board Advisor when you send the copies.

H. Confidential Information:

Because the record in Board proceedings may be disclosed to the public, the parties must carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, or other information that identifies individuals.

1. If the parties need to include materials with patient names, numbers, or other identifying information, they must redact (untraceably remove) the names and numbers and replace them with non-identifying sequential numbers. If the confidential information itself is necessary to support your position, submit a sealed envelope containing the confidential information with a cross reference to the non-identifying sequential numbers.

Rule 28 - Witness List

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

If you intend to qualify a witness as an expert (see Rule 34), designate his/her field of expertise and state the subject of the testimony. You must also forward with your witness list:

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

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

The Board may conduct a status conference at any time on the Board's own motion or request of either party to the Board Advisor. Before a scheduled hearing date, the Board may schedule a status (pre-hearing) conference to, among other reasons, narrow issues and discuss logistics to facilitate the hearing. The parties 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 or video
Estimated length of hearing
Audio and visual needs
Accommodations for disabled visitors

PART III: HEARINGS AND DECISIONS

Rule 30 - Hearing Dates/Postponements

30.1 - Notice of Board Hearing

The Board will issue a Notice of Hearing setting the hearing date and final position paper due dates. The hearing date established by this notice will serve as the initial hearing date that governs deadlines for final position papers (Rule 27), discovery (Rule 26), 42 CFR §405.1853(e), subpoenas (Rule 47) and 42 CFR §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

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

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

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

C. Requests due to Schedule Conflicts - If upon receipt of your Notice of Hearing, you have a scheduling conflict, or an unforeseeable conflict later arises, it is expected that you notify the Board as soon as possible and set out the detail of the conflict (e.g., the name and case number and the court where an appearance is required) The Board will consider promptly filed, reasonable requests, to reschedule the case to a nearby (earlier or later) date.

Rule 31 - Requesting Accelerated Hearing Date

31.1 - Request

When a party is fully prepared to present its case, it may request that the case be set at the earliest possible date (or within a specified range of dates). The request should demonstrate that the case has no impediments to a hearing (such as outstanding motions or discovery requests), and documentation exchange is complete. The request must also state whether the non-moving party concurs. If granted, the Board may establish such deadlines or impose such conditions as may be appropriate.

31.2 - Firm Hearing Date

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

Rule 32 - Methods of Appearance

32.1 - General Rule - In-Person Hearing

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

32.2 - Telephone Hearing and Video Hearings

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

B. Video Hearings: The parties may request to present all or part of their case by videoconference. An appropriate case is one in which there is limited need to refer to exhibits or one in which a witness is distant and appearing in person would cause undue hardship or expense. If a video hearing is granted, the parties are responsible for contacting their assigned Board Advisor in advance of the hearing to ensure/test connectivity.

C. Witnesses in a Telephone or Video Hearing: Remote witnesses will be asked to identify any other individuals and documents with them during the testimony. Upon objection or upon the Board's own motion, the individuals who are not testifying may be required to leave the room. It is the responsibility of the party calling a remote witness to ensure that the witness has available both parties' organized and labeled exhibits.

32.3 - Record Hearing

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

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

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

Rule 33 - Conduct of Hearing

33.1 - General

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

33.2 - Sequence

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

33.3 - Opening Statements

The parties should open with a brief statement to serve as a "road map" for the presentation. The parties should summarize the undisputed facts, the legal questions at issue, and the nature of the testimony and evidence expected to be presented during the examination of their witnesses.

33.4 - Witness Examinations

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

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

B. Order of Questioning: Unless the parties agree otherwise, the typical order of questioning is as follows, beginning with the Provider's witnesses:

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

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

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

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

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

33.5 - Closing Arguments

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

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

Upon adjournment of the hearing, no further evidence may be submitted unless the Board asks for or authorizes additional evidence to be submitted post hearing. However, the Board, on its own motion or by motion of a party, also has the discretion to reconvene a hearing to receive additional evidence or testimony.

Rule 34 - Expert Witnesses

34.1 - Expert Witness – Defined

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

34.2 - Expert Qualification

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

34.3 - Expert Report

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

Rule 35 - Hearing Materials

35.1 - Stipulations

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

Example 1: The parties stipulate that a transaction was a statutory merger under the laws of Georgia, [thus eliminating the need for proof from a Georgia legal expert but a dispute may remain as to what is the reimbursement effect of the merger.]

Example 2: The parties stipulate that "the Provider meets the requirements for an exception as an atypical Provider under regulation x." [That stipulation does not preclude a challenge to whether the Provider met the second part of the regulatory requirement to show that its excess costs were due to atypical services and costs.]

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

35.2 - Documentary Evidence

Except on agreement of the parties, documentary evidence relevant to fact disputes must be identified and exchanged by the deadline established in the JSO or by these rules. The parties are encouraged to discuss whether there will be objections to exhibits prior to the hearing and attempt to work out differences. If the parties agree, exhibits may be added up to the time of the hearing. Generally, additional legal authorities or summaries will not be subject to these time limits. At the commencement of the hearing, the Board will ask the parties to identify their respective exhibits and will ask if there are any objections to the opposing party's exhibits. Upon objection, the Board will determine the propriety of permitting late filed exhibits, taking into account the reasons for the late filing and the requirements of Rules 23 through 27*,* and prejudice to the opposing party.

35.3 - Visual Aids

A. **Prepared Prior to the Hearing**: The Board encourages the use of visual aids that facilitate presentation of evidence (charts, diagrams, large print copies, power point presentations, etc.). Visual aids should not contain material not previously submitted to the opposing party. The Board also requests that an 8 ½ x 11 copy of any visual aid be submitted to the opposing party and to the Board (6 copies) in advance of the hearing. For clarity in the record, a copy of a visual aid should be added as an exhibit at the hearing.

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

35.4 - Summaries

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

35.5 - Deposition Testimony and Interrogatories

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

35.6 - Affidavits

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

35.7 - Prior PRRB testimony

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

35.8 - Transcript

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

Rule 36 - Post Hearing Submissions: Briefs, Proposed Decisions, and Evidence

36.1 - General

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

36.2 - Post Hearing Brief

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

36.3 - Proposed Decisions

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

Rule 37 - Board Decision

The Board decision is final and binding upon all parties to the hearing except as provided in 42 CFR §405.1871(b). Board decisions are available on the Board's website at www.hcfa.gov/regs/prrb.htm.

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

A quorum of the Board is required to issue a hearing decision but a quorum is not required to hold a hearing. A Provider may file a written request for a quorum of Board members to conduct a hearing. Every effort will be made to have a full Board available on the day of the hearing.

PART IV: OTHER GENERAL RULES

Rule 39 - Abeyance Requests

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

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

Rule 40 - Contact with the Board Staff

40.1 - Do Not Directly Contact Board Members

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

40.2 - Ex Parte Communications

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

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

Rule 41 - Dismissal or Closure

41.1 - Parties' Motion

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

41.2 - Own Motion

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

1. if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
2. upon failure of the Provider to comply with Board procedures, or (See 42. CFR §405.1868),
3. if the Board is unable to contact the Provider or representative at the last known address, or
4. upon failure to appear for a scheduled hearing.

Rule 42 - Expedited Judicial Review

42.1 - General

A Provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review (EJR) of a final determination of reimbursement that involves a challenge to the validity of a statute, regulation or CMS ruling. Board jurisdiction must be established prior to granting an EJR request. In an appeal containing multiple issues, EJR may be granted for fewer than all the issues. The Board will conduct a hearing on the remaining issues. The Board will make an EJR determination within 30 days after it determines that it has jurisdiction and the request for EJR is complete. See 42 CFR §405.1842.

42.2 - Requests for EJR

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

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

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

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

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

42.3 - Content of the Request

A Provider must file a written request for EJR that:

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

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

Rule 43 - Mediation

43.1 - General

Providers and Intermediaries can resolve their dispute informally through the use of a form of alternate dispute resolution, i.e., mediation. The Board's mediation program is a flexible, confidential process designed to facilitate voluntary resolution. Mediation sessions are conducted by trained mediators from the Office of Hearings. Mediators help to improve communication, help the parties articulate their position and understand those of their opponent. The mediators facilitate resolution but do not render a decision or dictate a settlement. 90-95% of cases that are mediated are resolved without a hearing.

43.2 - Requesting Mediation

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

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

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

43.3 - Scheduling Mediation Sessions

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

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

43.4 - Participating in a Mediation Session

The parties are required to have in attendance at the session someone with the authority to settle the matters at issue and sign the mediation agreement. The parties may be represented by counsel or a consultant. All proceedings at the mediation shall be confidential, including all settlement negotiations.

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

Rule 44 - Motions

44.1 - In Writing

All motions (including jurisdictional challenges) to the Board are to: 1) be made in writing, 2) set out the legal and factual basis supporting the motion and, 3) include supporting documentation. (See Rule 30 regarding requirements for postponement requests).

44.2 - Duty to Confer

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

I conferred with ________________________ concerning the foregoing _________________________ [motion/request and ____ he/she _______ [does/does not] oppose the ______________ [motion/request, etc]

I conferred with ________________________ concerning the foregoing ___________________ [motion for extension, request for discovery, etc.] by ___________________ [give details of attempts; for example, by leaving five telephone messages but was unable to discuss the matter.]

44.3 - Time for Filing Response

Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within thirty days from the date that the motion was sent to the Board and opposing party.

44.4 - Jurisdictional Challenges - Timing

Jurisdiction may be challenged at any time. However, the Board expects that jurisdictional challenges be raised pursuant to the timeframes below:

- **Individual cases.** The Board expects the Intermediary to have thoroughly reviewed the Provider's claimed basis for jurisdiction and raise any jurisdiction challenges, by the filing of the PJSO or, if applicable, by the filing of the Intermediary's preliminary position paper (See Rule 25).
- **Group cases.** Within 30 days of receipt of the Board's Acknowledgement of Group Appeal, the current lead Intermediary must file a written statement with the Board addressing whether: 1) the group complied with the initial filing requirements 2) jurisdiction (subject matter) is proper, and 3) the issue is suitable for a group appeal. (See Rule 15). Also, within 60 days of receiving the Schedule of Providers, the final lead Intermediary must file a statement regarding whether jurisdiction is proper for each Provider in the group (See Rule 22).

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

Rule 45 - Recusal of Board Members

45.1 - General/On Own Motion

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

45.2 - Party May Request Recusal

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

45.3 - Recused Board Members

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

Rule 46 - Reinstatement

46.1 - Request

A request for reinstatement must be in writing, must be made within three years (see 42 CFR §405.1885) after the date of the notice of dismissal or closure, and must set out the reasons for reinstatement.

46.2 - Failure to Implement Administrative Resolution

Upon a written motion showing a case was closed pursuant to an administrative resolution, and the Intermediary failed to issue a final determination (e.g., revised NPR) as agreed, and the Provider was not at fault, the Provider may file a reinstatement request within three years from receiving the Board's closure letter.

46.3 - Dismissals for Failure to Comply with Board Procedures

Upon written motion demonstrating good cause, a case dismissed for failure to comply with Board procedures may be reinstated. 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 a paper with the Board that was required, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.

Rule 47 - Subpoenas

47.1 - Only the Board Can Issue a Subpoena

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

- be sent via overnight mail or delivery service
- have the outside of the envelope marked "SUBPOENA REQUEST"
- be sent to the following:
    - The Board,
    - The individual to be subpoenaed (or the custodian of records being subpoenaed) and
    - all parties to the appeal.
- state if the individual is requested to appear in person or by telephone. If a telephone appearance is not satisfactory, explain why.
- If the subpoenaed individual is a non party, include a notice that the individual may respond to the Board either upon notice of the request or upon issuance of the subpoena, if the Board approves the request.

47.2 - Response

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

Rule 48 - Withdrawal of Appeal

It is the Provider's responsibility to withdraw cases in which an administrative resolution has been executed or which the Provider no longer intends to pursue. See Rule 46 on reinstatement if the administrative resolution is not effectuated as agreed.

Rule 49 - Intentionally left blank

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

50.1 - General

CHGME is funded through an appropriation to the Department of Health & Human Services, the Health Resources & Services Administration, and the Bureau of Health Profession. (See **http://bhpr.hrsa.gov/childrenshospitalgme/**)

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

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

50.2 - Process for Filing a CHGME Appeal

A. Time for Filing

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

B. Where to File

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

C. Telephone Notice to Board

Please call the Division of Jurisdiction and Case Management at (410) 786-2053 and indicate the date and method of delivery for submitting the Provider's request.

D. No Supporting Documentation to Board with Initial Filing

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

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

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

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

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

50.3 - Filing CHGME Appeal: Content and Format

The appeal must contain the following:

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

50.4 - Board Acknowledgement of Filing CHGME Appeal

The Board will notify you of position paper due dates and the date of hearing after receipt of your 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

You may have as little as one week to file position papers, depending on the date of your filing and the Board's hearing schedule. Position papers must conform to Rule 27.

50.6 - Public Health Service Response to CHGME Appeal

The response to the CHGME appeal is to conform to rules relating to other appeals. The Board will set the time for response in the Acknowledgement.

50.7 - Extensions/Postponements

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

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

MODEL FORM A – INDIVIDUAL APPEAL REQUEST

Date of Request: ____________________

Does this Request for Hearing include a request for Expedited Judicial Review?
_____YES   _____ NO (Note: A request for EJR must be submitted in a separate document and "EJR Request" must be marked on the outside of the envelope or package transmitting this appeal.)

Does this Request for Hearing include a request for Mediation?
_____YES   _____   NO

Date of Final Determination:_____________________
Type of Final Determination:_____ Notice of Program Reimbursement (NPR)
(Check One)   _____ Revised NPR
_____ Exception Determination
______ Federal Register Notice
______*Failure to Issue a Timely Determination
______ Other (specify:_______________________)

YOU MUST ATTACH THE FINAL DETERMINATION UNDER A **TAB LABELED 1**.

If receipt of Final Determination is more than five days after date of determination, state date received: _____________________ (Attach evidence of date of receipt.)

***If claiming Intermediary failed to issue a timely Final Determination, state date cost report was sent to intermediary: ___________________________**
(a copy of the cost report certification page and any other evidence to support the date the cost report was filed.)

FYE (1 per appeal request)________________________________

Provider Information

Provider No.: ___________________________
Provider Name: __________________________
Provider Contact/Title: ________________________
Provider Address: ___________________________
____
____

Provider's Telephone No.: ____________________
Provider's Fax No.: _____________________
Provider Contact's E-mail address: _______________________

Is this Provider commonly owned or controlled? _____YES _____ NO

If YES, identify the name of the corporation, name of the contact person at the corporation, the address and telephone number:

____

____

Intermediary Information

Intermediary Name:_________________________________
Address: ___________________________
____
____
Intermediary Code: _________________________________
(from NPR, if known)

Representative Information (if applicable)

Representative's Name:______________________________________
Company Name and Address: ____________________________
____
____
Phone Number:_______________________
Representative's Fax No.: ____________________
E-mail address:______________________________________

UNDER A **TAB LABELED 2**, YOU MUST ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION.

Issue(s) Appealed

UNDER A **TAB LABELED 3** YOU MUST SUBMIT A STATEMENT FOR EACH ISSUE. The statement of the issue must conform to the requirements of the regulations found at 42 CFR §405.1835 et seq. and the Board's Rules and include:

_______ a brief description of the issue
_______ the audit adjustment number(s)
_______ the amount in controversy; and
_______ a statement identifying the legal basis for the appeal.
(Cite statutes and/or regulations and/or manual provisions.)

Total Amount in Controversy for all issues: ________________________
(Amount Medicare payment would increase if appeal of all issues is successful)

CERTIFICATIONS:

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

Printed Name: ________________________
Title: ________________________________

Signature: ____________________________
Provider Owner/Officer or Designated Representative

Date:________________________

B. I hereby certify to the best of my knowledge that there is no other provider to which this Provider is related by common ownership or control that has a pending request for a Board hearing on any of the same issues contained in this hearing request for cost reporting periods that end in the same calendar year covered in this hearing request. (See 42 C.F.R. §405.1837(b)(1)(i).

Signature: ____________________________
Provider Owner/Officer or Designated Representative

Date:________________________

C. Certificate of Service: I certify that a copy of this Request (and all supporting documentation) was sent by (**Check one**)
________United States Postal Service
________Nationally recognized courier. Specify Name: _________________________

to the Intermediary on this __________day of _____________, 2 _ _ _

Certified Mail or Tracking Number: _________________________________

Signature: ____________________________
Provider Owner/Officer or Designated Representative

Date:________________________

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

MODEL FORM B - GROUP APPEAL REQUEST

Date of Request: ________________________

Does this Request for Hearing include a request for Expedited Judicial Review?
_____ YES _____NO (A request for EJR must be submitted on a separate document and "EJR Request" must be marked on the outside of the envelope or package transmitting this appeal.)

Does this Request for Hearing include a request for mediation? _____YES _____NO

Does this Request include all providers that will be in the group?_____YES _____ NO

Type of Group (Check one):
______ Optional (providers are not commonly owned or controlled)

______ Mandatory (providers are commonly owned or controlled – CIRP Group)
(Common Issue Related Parties (CIRP))
If mandatory group: name, contact information (including phone & e-mail) and address of common owner/control organization:
____
____
____

FYE(s) IN DISPUTE: ______________________

PROPOSED GROUP NAME (include corporate name for CIRP and subject of issue under appeal:____

Representative Information

Representative's Name:_____________________________

Company Name and Address: _____________________________
____
____

Phone Number:____
FAX Number:____
E-mail address:____

PROVIDER INFORMATION

Number of Providers creating group: ________

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

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

Type of Final Determination (Check One)**:**

Provider 1	**Provider 2**	
_____	______	Notice of Program Reimbursement (NPR)
_____	______	Revised NPR
_____	______	Exception Determination
_____	______	Federal Register Notice
_____	______	Failure to Issue a Timely Determination

Lead Intermediary Information

Intermediary Name:___________________________________
Address:____________________________
____
____
Intermediary Code: __________________________________
(From NPR, if known)

Issue Under Appeal (1 per group)

UNDER A TAB LABELED 2 YOU MUST SUBMIT A STATEMENT OF THE GROUP ISSUE. This statement of the issue must conform to the requirements of the regulations found at 42 CFR §405.1837 et seq. and the Board's Rules and include a brief description of the issue and the legal basis for the appeal. (Cite statutes and/or regulations and/or manual provisions.)

CERTIFICATIONS

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

Printed Name: ______________________

Title: _____________________________

Signature: _________________________
Group Representative

Date: ____________________

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

Printed Name: ______________________

Title: _____________________________

Signature: __________________________
Group Representative

Date: ____________________

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

_______ Nationally recognized courier. Specify name: ____________________

to the lead Intermediary (if known) and the local Intermediary (if different) on this __________day of _________________, 2_ _ _

Certified Mail or Tracking Number: ____

Signature: _______________________________ Date: __________________________
Group Representative

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

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

Date of Request: _____________________

Does this Request to Add an Issue include a request for Expedited Judicial Review?
_____ YES ______NO (A request for EJR must be submitted on a separate document.)

Does this Request to Add an Issue include a request for Mediation?
_____ YES ______NO

A provider may add issues to an appeal as long as the request conforms to the requirements of 42 CF.R §405.1835(c).

Individual PRRB Case No.: __________________

Provider Name: ____________________________

Provider No.:______________________________

FYE: _____________________________________

Date of Original Hearing Request: __________________________

Issue(s) Being Added to Case:

UNDER A **TAB LABELED 1** YOU MUST SUBMIT A STATEMENT FOR EACH ISSUE BEING ADDED TO THIS APPEAL. The statement of the issue(s) must conform to the requirements of the regulations found at 42 CFR § 405.1835 et seq. and the Board's Rules and include:

______a brief description of the issue
______the audit adjustment number(s)
______the amount in controversy
______a statement identifying the legal basis for the appeal.
(Cite statutes and/or regulations and/or manual provisions.)

Representative Information

Are you the representative for this individual appeal? _____YES _____NO
(If you check "NO" you must attach an authorization signed by an official of the Provider.)

Certifications

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

Printed Name: ____

Title: ____

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

Date: ________________________

B. I certify to the best of my knowledge that there are no other providers to which this Provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues contained in this hearing request for a cost reporting period that ends in the same calendar year covered in this request.

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

Date: ________________________

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

__________ Nationally recognized courier. Specify name: ______________________

to the intermediary on this __________day of ______________, 2 _ _ _

Certified Mail or Tracking Number: __________________________________

Signature: ________________________________ Date: __________________
(Provider Owner/Officer/Director or Representative)

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

MODEL FORM D - REQUEST TO TRANSFER ISSUE TO A GROUP APPEAL
YOU MUST FILE AN ORIGINAL AND ONE COPY OF THIS FORM

Date of Request: ____________________

Original PRRB Case No.: __________________

Provider Name: __________________________

Provider No.:_____________________________

FYE: __________________________________

Description of Issue that is being transferred: ______________________________
(Include audit adjustment number if applicable.)

Was the issue included in the Provider's initial appeal? ______YES _____NO
If "NO"

Was the issue added to the Provider's pending appeal? ______YES _____NO
NOTE: The issue must be included in the individual appeal before it can be transferred to a group appeal. See, 42 CFR §405.1835.

PRRB Group Case Number to which issue is being transferred: ________________

Is this a commonly owned or controlled Provider? _____YES _____ NO

Is this a common issue related party (CIRP) group appeal? _____YES _____ NO

Is the Provider a member of the CIRP? _____YES _____NO

Note: (See Rule 12.5) Independent hospitals may not participate in CIRP groups. If a CIRP provider is participating in a group appeal involving independent hospitals, you must explain why this action is appropriate in the space below:
____
____
____.

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

If NO, you will be required to submit an authorization of representation signed by an official of the Provider when you submit the final Schedule of Providers with the associated jurisdictional documentation.

IF THE GROUP APPEAL TO WHICH YOU ARE REQUESTING TO TRANSFER HAS NOT BEEN ASSIGNED A CASE NUMBER, PLEASE PROVIDE THE FOLLOWING INFORMATION OR A COPY OF THE REQUEST FOR A GROUP:

Date of Group Appeal Request: ________________________________

Group Representative's Name: _________________________________

Group Representative's Contact Information: ____________________
____
____
____

Name of Group Appeal: ____________________________________

Certifications

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

Printed Name: ______________________	Printed Name: _______________________
(Provider/Rep. Transferring Issue)	(Group Rep.)
Signature: _________________________	Signature: __________________________
Date: ______________________________	Date: ______________________________

D. I have reviewed the regulations at 42 CFR §405.1837, the Board Rules and consulted with the other representative listed on this form. I have a good faith belief that this transfer request meets the single common issue requirement for a group appeal.

Signature: _________________________	Signature: __________________________
(Provider/Rep. Transferring Issue)	(Group Rep.)
Date: ______________________________	Date: ______________________________

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

__________United States Postal Service

__________ Nationally recognized courier. Specify name: ________________________

to the lead intermediary (if known) and the local intermediary (if different) on this __________day of ______________, 2 _ _ _

Certified Mail or Tracking Number: ________________________________

Signature: ______________________________ Date: _________________
(Group Rep.)

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

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

Date of Request: ____________________

Description of Issue: ____
(Include audit adjustment number if applicable.)
Provider Name: ___________________________
Provider No.:_______________________________
FYE:_____________________________________

Provider Contact/Title: ______________________________________
Mailing Address: ____
____
____
Telephone Number: ____________________
Fax Number: __________________________
E-mail Address: _______________________

Date of Final Determination: ________________________
Type of Final Determination: (Check One)
_____Notice of Program Reimbursement (NPR)
_____Revised NPR
_____ Exception Determination
_____Federal Register Notice
_____Failure to Issue a Timely Determination
_____Other (Specify: ____________________)

THE GROUP REPRESENTATIVE WILL BE REQUIRED TO SUBMIT A COPY OF THE FINAL DETERMINATION AND SUPPORTING DOCUMENTS ONCE THE GROUP IS COMPLETE.

If receipt of Final Determination is more than five days after date of determination, state date received: _______________________

If claiming intermediary failed to issue a timely final determination, state date cost report was sent to intermediary: _______________________
(THE GROUP REPRESENTATIVE WILL BE REQUIRED TO PROVIDE A COPY OF THE COST REPORT CERTIFICATION PAGE AND ANY OTHER EVIDENCE TO SUPPORT THE DATE THE COST REPORT WAS FILED ONCE THE GROUP IS COMPLETE.)

NOTE: The filing of a group appeal does not constitute a timely filing for an individual appeal. See 42 CFR §405.1837(g).

<u>PRRB Group Case Number to which Provider is being added:</u> ________________

Group Case Name: ____

Is this a commonly owned or controlled Provider? _____YES _____ NO

Is this a common issue related party (CIRP) group appeal? _____YES _____ NO

Is the Provider a member of the CIRP? _____ YES _____NO

Note: (See Rule 12.5) Independent hospitals may not participate in CIRP groups. If a CIRP provider is participating in a group appeal involving independent hospitals you must explain why this action is appropriate in the space below:

____

____

IF THE GROUP APPEAL TO WHICH YOU ARE REQUESTING TO BE ADDED HAS NOT BEEN ASSIGNED A CASE NUMBER, PLEASE PROVIDE THE FOLLOWING INFORMATION OR A COPY OF THE REQUEST FOR A GROUP:

Date of Group Appeal Request: _________________________________

Group Representative's Name: __________________________________

Group Representative's Contact Information: _____________________

____

____

____

Name of Group Appeal: ____

Certifications

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

Printed Name: ______________________ (Provider/Rep. Adding Issue)

Signature: _________________________

Date: _______________________

Printed Name: _______________________ (Group Rep.)

Signature: __________________________

Date: _____________________

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

Signature: _________________________ (Provider/Rep. Adding Issue)

Date: _______________________

Signature: __________________________ (Group Rep.)

Date: _____________________

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

__________United States Postal Service

__________ Nationally recognized courier. Specify name: _____________________

to the lead intermediary of the group (if known) and the local intermediary (if different) on this __________day of ______________, 2 _ _ _

Certified Mail or Tracking Number: ____________________________

Signature: _______________________________ Date: _________________
(Group Rep.)

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

MODEL FORM F: PROPOSED JOINT SCHEDULING ORDER

Date of Request: ______________________

Case # _____________

Provider/Group Name ________________
Provider/Group FYE_________________
Provider(s) # ____________________

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

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

1. A brief statement of the issue.

2. A description of the conditions on which resolution is based, including dates, actions, and audit methodologies required by the parties. [Example: Issue 1 is whether the Provider's travel expenses were adequately documented--The issue is conditionally resolved based on the Provider's representation that it will furnish the September 2004 travel logs by June 1, 2008.]

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

1. A brief statement of the issue.

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

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

4. Listing of documentation exchanged to date.

5. If the parties expect the case to require discovery, or a voluntary exchange and analysis of data, create a detailed timetable/schedule for that exchange. This schedule will supersede the timelines in the regulations as permitted by 42 CFR 405.1853(e)(3)).

[Example: Unresolved Issue 1 is Medicaid Eligible Days –
January 1, 20xx – Provider will submit to Intermediary an updated Medicaid eligible days listing.
February 1, 20xx – Intermediary will have sampled listing and given sampled items to Provider with request for supporting documentation.
March 1, 20xx – Provider will supply all documentation requested by the Intermediary in support of the sample.
March 15, 20xx - Intermediary will have reviewed documentation submitted by Provider in support of sample and will inform Provider of audit findings. Additional documentation requests will be provided by this date.
April 1, 20xx – Provider will respond to audit findings with any additional documentation.
April 15, 20xx – Intermediary will submit finalized adjustments to Provider.
May 1, 20xx – Final Administrative Resolution will be drafted or parties will inform PRRB that an Administrative Resolution can not be reached.

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

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

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

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

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

Provider Representative	**Intermediary Representative**
____________________	____________________
Signature	**Signature**
____________________	____________________
Print Name and Title	**Print Name and Title**
____________________	____________________
Date	**Date**

Model Form G: Schedule of Providers in Group

Group Name ____________________ Page ____ of ____

Representative ____________________ Date Prepared ________

Case No. ____________ Issue ____________

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer

SCHEDULE OF PROVIDERS

Schedule of Providers in Group

Group Name: 99 - 01 DSH Dual Eligible Days
Representative:
Case No.: G

Issue: Whether those dual eligible patients not processed as PPS, including those who have exhausted their Medicare Part A benefits, should be included in the Disproportionate Share Hospital (DSH) calculation.

	Provider Number	Provider Name	FYE	Intermediary	A Date of Final Determ	B Date of Hearing Rqst	C No. of Days	D Audit Adj. No.	E Approx. Amount	F Orig. Case No.	G Date of Add/Transfer
1			6/30/2001	United Government Services	9/28/2005	3/17/2006	170	31 - 33	$ 509,470		7/28/2006
2			6/30/2001	United Government Services	9/16/2005	3/13/2006	178	55,56	$ 468,627		7/28/2006
3			6/30/2002	United Government Services	9/19/2005	3/16/2006	178	39,40	$ 249,392		7/28/2006
4			6/30/2001	United Government Services	9/15/2005	3/10/2006	176	46	$ 16,034		7/28/2006
5			6/30/2002	United Government Services	9/15/2005	3/10/2006	176	34,35	$ 63,601		7/28/2006
6			6/30/2000	United Government Services	9/9/2003	3/5/2004	178	69,70,75	$ 419,507		7/28/2006
7			6/30/2000	United Government Services	8/13/2004	2/7/2005	178	49 - 54	$ 113,648		7/28/2006
8			6/30/2001	United Government Services	9/14/2005	3/10/2006	177	30,33,34	$ 99,378		7/28/2006
9			6/30/2001	United Government Services	3/31/2005	7/1/2005	92	2	$ 48		10/28/2005
									$ 1,939,705		

1A

PART A INTERMEDIARY NATIONAL FQHC INTERMEDIARY MEDICARE

REGIONAL HOME HEALTH INTERMEDIARY PHONE 805-367-0800

RECEIVED OCT 05 2005

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

September 28, 2005

SUBJECT: NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

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

Dear :

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

Attached please find:

Exhibit	Title
A	Summary
B	Appeal Rights
C	Form of Report

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

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

UNITED GOVERNMENT SERVICES, LLC.

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

letters\NPR\ NPR4.DOC \12/29/04

1B

[redacted]
Telephone: [redacted]
Fax: [redacted]

March 17, 2006
Certified #7004 2890 8261 4843

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

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

Dear Mr. Kirsh:

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

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

   The Provider appeals whether the Intermediary was correct in disallowing bad debts for the following issues:
   - ($9,665) - Discrepancy between allowed Medi-Medi Crossovers bad debts and actual in Adjustment 30.
   - ($66,600) - Unprocessed Inpatient Medi-Medi Crossovers Bad Debts protested in Adjustment 41.

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

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

1D

PEAT MARWICK MICRO-COMPU-MAX SYSTEM HCFA-2552-96 AUDIT ADJUSTMENT REPORT RUN DATE: 09/26/2005 PAGE 12
PROVIDER NAME: [redacted] PROVIDER NUMBER: [redacted] FISCAL PERIOD: 07/01/2000 TO 06/30/2001

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

1E

9/29/2006

DSH CALCULATION						
FYE 6/30/01						
PROVIDER NO.						
Medi-Cal Days	**UGS Calc As of 9/26/05**		**Impact of Dual Eligible Days**		**Impact of Share of Cost Days**	
			7,792		7,792	
			194		194	
Total Paid Days	7,102		7,986		7,986	
Eligible Days - Adult Days (Code 1 & Code 2)	2,939		2,939		2,939	
Eligible Days - Baby & Mother (Code 1 & 2 Moms)	1,257		1,257		1,257	
Less: CWF Pt A Entitled Unpaid Days (Code 1)	(984)		0		0	
Less: Code 2 Adult Days	(263)		(263)		0	
Less: Code 2 Baby Days	(30)		(30)		0	
Less: Code 1 Mom's Admit 1 Day Prior (LRDP Days)	(166)		(166)		(166)	
Additional days found during audit	11					
Less: IP Part B Days (0.1% Total Paid Days)			(8)		(8)	
Less: Audit adj	(32)					
Total Medi-Cal Eligible Days	**9,834**		**11,715**		**12,008**	
Total Patient Days (S-3)	64,310		64,310		64,310	
Less: Total LRDP Days	(766)		(766)		(766)	
Adjusted Hospital Days	**63,544**		**63,544**		**63,544**	
MEDI-CAL PERCENTAGE	**0.15476**		**0.18436**		**0.18897**	
SSI RATIO	**0.11034**		**0.11034**		**0.11034**	
SSI ADJ						
REVISED SSI % PER PROVIDER						
DSH Patient Percentage	0.26510		0.29470		0.29931	
Qualifying Threshold	0.20200		0.20200		0.20200	
Difference	0.06310		0.09270		0.09731	
Percentages	0.82500		0.82500		0.82500	
Line 9 times line 10	0.05206		0.07648		0.08028	
Add On Percentage	0.05880		0.05880		0.05880	
DSH Payment Adjustment Factors	**0.11086**		**0.13528**		**0.13908**	
	0.11090					
	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)	Prior 4/01/01 (9 Months)	After 4/01/01 (3 Months)
Total Federal Payments	16,571,336	5,865,147	16,695,194	5,565,065	16,695,194	5,565,065
DSH Payment	1,837,761	650,445	2,258,490	752,830	2,322,000	774,000
DSH Reduction Factor	3.0%	1.0%	3.0%	1.0%	3.0%	1.0%
DSH Reduction Amount	(55,133)	(6,504)	(67,755)	(7,528)	(69,660)	(7,740)
Total DSH Amount	1,782,628	643,940	2,190,736	745,302	2,252,340	766,260
Total DSH Payment	**2,426,568**		**2,936,037**		**3,018,600**	
DSH amount, per previous calculation	(2,426,568)		(2,426,568)		(2,936,037)	
Impact	**(0)**		**509,470**		**82,562**	

1G

file

Telephone:
Fax:

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

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

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

Dear Ms. Cochran:

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

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

Please contact us if you have any questions.

Sincerely,

Vice President