PG Bulletin
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Provider Reimbursement Review Board Proposed Rules 3.0

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On June 16, 2021, the Provider Reimbursement Review board (Board) issued Alert 21, entitled "Mandatory Electronic Filing & Revised PRRB Rules, Effective November 1, 2021 and Change of Address, Effective Immediately."[1] Alert 21 serves public notice of "revisions to the Board Rules, which are ***effective November 1, 2021*** and will supersede all previous rules and instructions. The Board Order adopting mandatory electronic filing and the revised Board Rules implementing this mandate as well as other revisions." The proposed revisions to the Board Rules supersede Rules 2.0 (August 29, 2018). Comments may be submitted by July 30, 2021.

Highlights

As summarized by Alert 21, Board Rules 3.0, "the highlights of these updates include, but are not limited to:

- Updates the Provider Reimbursement Review Board filing rules, making electronic filing using the Office of Hearings Case and Document Management System ("OH CDMS") mandatory, unless an exemption applies.
- Eliminates filing of Schedules of Providers ("SoP") for group cases fully populated in OH CDMS. NOTE: For cases *not* fully populated in OH CMDS, the SoP must be filed electronically in OH CMDS and, in certain specific situations, a hard copy of the SoP must also be filed (*e.g.*, when a request for expedited judicial review is filed, a hard copy of the SoP must be filed in addition to the concurrent or prior electronic filing of the SoP).
- Updates case representatives' responsibilities to include familiarizing themselves with OH CDMS, as the required Board filing system and Board rules and procedures.
- Allows for the issuance of Board Orders, in lieu of Board Alerts, as an extension of the Board Rules.
- Requires providers to include information on parent owner or organization with an appeal request (as required by the regulation 42 C.F.R. §§ 405.1835(b)(4), (d)(4)).

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- Updates the Board's address to the following new mailstop because the Board is moving to a new permanent home, ***effective immediately***:

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

- Updates rules for substantive claim challenges (relating to cost reporting periods beginning on or after 1/1/2016) and responses to said challenges pursuant to 42 C.F.R. § 412.24(j) and 42 C.F.R. § 405.1873(a).
- Updates the requirements for requests to postpone a hearing.
- Removes the blanket requirement to file 6 courtesy hard copies of briefs and exhibits 10 days prior to a scheduled Board hearing.
- Officially adds video conferencing and video hearings as options for pre-hearing status calls and for actual hearings.
- Sets a deadline for the Medicare Contractor to file responses to requests for Expedited Judicial Review ("EJR").

Discussion and Commentary

Competent practice before the Board requires that Providers and their representatives be fully acquainted with Rules 3.0 (as well as with the codified regulations[2]) to assure effective practice before the Board. This article does not substitute for that requirement. The following is a commentary on some of the significant features of Rules 3.0.

Electronic Filing (See Rule 3)

The most significant impact of Rules 3.0 is that, with narrow exceptions, all filings must be made via the electronic filing system, "OH CDMS." The OH CDMS was launched in September of 2019 and has been upgraded several times. In the author's experience, the OH CDMS it is a vast improvement over the prior hard copy filing requirements in numerous respects: timely receipt of filings by the Board and the parties is assured and memorialized, elimination of voluminous certified mail or private delivery service filings is a major cost-saving measure, and information and documents relating to a case can be readily reviewed and retrieved. One drawback, however, is that access to case files is restricted to the provider and its representative. Thus, in contrast to the PACER system the federal judiciary adopted nearly 20 years ago, one cannot review documents in other parties' cases.

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The Rules 3.0 recognize that technical difficulties arise in the electronic world and enable a party to request a deadline extension. Rule 2.1.3:

> To the extent the issue cannot be resolved by the Board-Set Deadline and the case representative makes a late filing, then the registered user should document their issues and submit their filing electronically within twenty-four (24) hours of the issue being resolved by the Help Desk. As part of this filing, the case representative must request an extension due to technical difficulties and provide satisfactory proof to establish good cause for the late filing. In this regard, the request should:
>
> - Describe the technical issue;
> - Describe when it was identified;
> - Describe their efforts to resolve the issue;
> - Identify the OH CDMS Help Desk ticket number opened to address the issue;
> - Include a copy of the notice from the OH CDMS Help Desk confirming that the technical issue was resolved; and
> - Confirm whether there are any other registered users in the case representative's organization and, if so, explain why the other user(s) could not make the filing. If the Board finds good cause for the requested extension, then the Board will accept the filing as timely.

Schedule of Providers (See Rule 20)

Rules 3.0 provides welcome relief to what is perhaps the most time-consuming, tedious, and error-prone task—preparation of the Schedule of Providers for a group appeal:

> If all the participants in a fully-formed group are populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (see Rule 21), then the representative is exempt from filing a hard copy of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group. (Introduction to Rule 20).

Upon establishment of a group appeal via the OH CDMS, the jurisdictional information and supporting documentation for each provider is submitted. Thus, if electronic filing is properly conducted, the Board will assemble the Schedule of Providers. This development eliminates the requirement that a voluminous, tabbed document be sent to the Board and the MAC. For the Board and the MAC, review of the Schedule of Providers is facilitated. For pending group appeals for which the OH CDMS is not fully populated with the necessary information and documentation, preparation and filing of hard copy Schedule of Providers will remain necessary.

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Courtesy Copies (Rule 35.1)
Current practice requires the parties to submit six additional courtesy copies of their respective position papers to the Board shortly before a hearing. As revised, Rules 3.0 eliminate this requirement, unless the Board requires otherwise:

> Parties are not required to submit additional copies of position paper(s) and exhibits that are populated in OH CDMS, unless directed to do so by the Board. If the Board requests that the parties furnish six (6) additional copies, those copies must be received at the Board ten (10) days before the hearing.

Responsibilities of Provider Representative (Rule 5.2)
Rules 3.0 provide as follows for more rigorous provider representative qualifications:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - Responding timely to correspondence or requests from the Board or the opposing party.

Information Regarding Provider Parent or Owner (Rule 6.6)
A new Rule 6.6 requires a provider to submit the following information regarding parent or owner organizations:

> Pursuant to 42 C.F.R. §§ 405.1835(b)(4) and 405.1835(d)(4), **if a provider is under common ownership or control, the appeal request must include the name and address of the parent corporation for the year under appeal.** Providers who are under common ownership or control must ensure they comply with the mandatory group requirements for common issues as delineated at 42 C.F.R. § 405.1837(b) and Rules 12.3.1, 12.11, 13, and 19.2. (Emphasis added.)

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Presumably the OH CDMS will be modified to establish a field for identifying the parent corporation.

Self Disallowance (Rule 7.3)
Among the most contentious procedural issue over many years is the requirement for self disallowance, i.e., the required actions to preserve the right to appeal an item the provider does not claim on the cost report. Rules 3.0 addresses the three requirements for the three relevant time periods, i.e., cost reporting periods beginning on or after 12/31/2008 and before 1/1/2016; and cost reporting periods beginning on or after 1/1/2016. Rule 7.3 should be carefully reviewed to assure compliance with the specific filing requirements for each time period. Note, however, that Rules 3.0 apparently continue to require a protested amount in the context of an appeal challenging a regulation for cost reporting periods beginning on or after 1/1/2016. As stated in Rule 7.4: “In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, provider’s cost report at issue in an appeal before the Board complies with the regulatory the provider's cost report (whether determined on an as submitted, as amended, or as adjusted basis) must include an appropriate claim for the specific item.” It is well established that for cost reporting periods beginning on or after 12/31/2008 and before 1/1/2016 an appeal of a regulation does not require the provider to file a protested amount.[3] Arguably a protested amount regarding an appeal of a regulation should not be required for appeals of cost reporting periods beginning on or after 1/1/2016, but Rules 3.0 does make an exception for this type of appeal.

Multiple Component Issues (Rule 8)
Each version of the Board Rules expands upon the need for a provider to specifically frame the issue regarding multiple component adjustments, such as DSH. The reader is commended to Rule 8 for the Board’s expanded discussion.

Numbering of Position Paper Exhibits (Rule 25.3.1.B).
To date the Board has required that Position Paper Exhibits be numbered individually in the upper right hand corner format of “P. 1 of 10, P. 2. of 10, P. 3 of 10, etc.” Rule 25.3.1.B now requires that Position Paper Exhibits be Bates numbered in the lower right hand corner.

Final Position Papers (Rule 27)
The reader is commended to Rule 27 which elucidates when a Final Position Paper is required and when a Preliminary Position Paper serves as the final.

Conclusion

As with prior versions, Rules 3.0 tend to impose additional burdens on the Provider, with numerous acts or omissions that can trigger involuntary dismissal. Providers and their representatives conducting appeals before the Board must be well versed in Rules 3.0 and

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should take the opportunity to carefully review the entire document and to submit comments before the Rules are finalized.

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[1] The full text of Alert 21 is available https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.

[2] 42 C.F.R. § 405.1835 et seq.

[3] See *Banner Heart Hospital et al. v. Burwell*, 201 F.3d. 131 (D.D.C. 2016); CMS Ruling 1727-R (4/23/2018); “A Funny Thing Happened On The Way To The PRRB: The Amended Cost Reporting and Appeals Rules,” Kenneth R. Marcus, *AHLA Connections*, June 2016.

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