QUALITY REPORTING APPEALS
FREQUENTLY ASKED QUESTIONS (“FAQs”)

1. What is the Provider Reimbursement Review Board?

A. The Provider Reimbursement Review Board (“PRRB” or “Board”) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination by its Medicare contractor or by the Centers for Medicare & Medicaid Services ("CMS").

2. Can the PRRB explain why the payment reduction was instituted or why the reconsideration was denied?

A. The PRRB does not make initial Annual Payment Update (“APU”) decisions and reconsideration determinations for the quality reporting programs (“QRPs”). Therefore, the Board does not have information regarding how or why a particular APU was reduced or a specific reconsideration request was denied. Questions about initial APU decisions should be directed to the appropriate QRP office. Questions regarding determinations reached upon reconsideration of initial APU decisions should be directed to the Center for Clinical Standards and Quality, which is responsible for processing provider appeals at the reconsideration level.

3. What is the PRRB appeals process?

A. You must file an initial appeal request through the Office of Hearings Case and Document Management System (“OH CDMS”) indicating your dissatisfaction with CMS decision and provide all of the data and documentation as identified in 42 C.F.R. § 405.1835(b) and the PRRB Rules. See https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders and also question 8 below.

The Board will acknowledge the appeal request and establish briefing deadlines for you to present arguments and evidence as to why you believe CMS’ payment reduction to be incorrect. Generally, the Provider’s preliminary position paper deadline is 8 months from the appeal filing date and the Medicare Contractor’s response is due 4 months later.

After the parties have filed their preliminary position papers, the case will be scheduled for a hearing. The Provider may request that its case be accelerated by submitting a written request in accordance with PRRB Rule 31.

It is imperative that Provider file a complete appeal request and comply with all deadlines established by the PRRB. Per 42 C.F.R. § 405.1868:

> If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

4. When is my appeal due?

A. Unless the provider qualifies for a good cause extension under 42 C.F.R. § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the Notice of Quality Reporting Program Noncompliance Decision Upheld. 42 C.F.R. § 405.1835(a)(3).

5. Can I submit my appeal through e-mail?

A. No, the Provider Reimbursement Review Board does not accept correspondence, including requests for appeal, via e-mail. You must file your appeal request through the Board's online case management system, the Office of Hearings Case and Document Management System ("OH CDMS"). *See* https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

6. Can I file my appeal in hard copy format instead of using OH CDMS?

A. No, as of November 1, 2021, all filings must be submitted electronically using OH CDMS unless an exemption is granted under PRRB Rule 2.1.2.

7. How do I register to use OH CDMS?

A. If you have not already done so, you must first request access to the CMS Salesforce Enterprise Integration ("SEI") Portal, which is a single port of entry to numerous CMS applications and systems. Then you must request access to OH CDMS via the Salesforce Application. To register, please follow the instructions in the OH CDMS External Registration Manual, which is available for download at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-electronic-filing.

If you have any difficulties or have questions regarding registering for either the CMS SEI Portal or OH CDMS, please contact the OH CDMS Help Desk at 1-833-783-8255 or by emailing Helpdesk_OHCDMS@cms.hhs.gov.

8. What is needed to file an appeal with the Board?

A. General Information

- **Provider Information:** Identify your Provider Name and Medicare Provider Number (also known as the CMS Certification Number). Note that most hospitals are pre-loaded in OH CDMS and may be selected from a drop-down list. Providers that do not find their organization information may enter relevant provider information and mailing address.
- **Parent Information:** Identify whether the provider is associated with a parent organization or home office for the year under appeal, and if so, what is that organization's name.
- **Medicare Administrative Contractor ("MAC") Information:** Identify your MAC Name & Code, that is, with whom do you file your annual cost report?

- **Representative Information:** Identify the company and contact name for the person who will submit correspondence on your behalf and represent your interests during PRRB proceedings. A letter of representation is required to be uploaded even if the Provider is representing itself or a parent organization is representing an affiliated provider. *See* PRRB Rule 5.

Determination Information.

- **Final Determination Type:** Select "Quality Reporting Payment Reduction."
- **Appealed Period:** Select from Cost Reporting Period, Federal Fiscal Year (ending 9/30), or Other (may be a calendar year or other 12-month period as identified by CMS). This period will be identified in the determination letter issued by CMS and it varies depending on the type of Quality Reporting Program.
- **Copy of Final Determination Letter:** Upload a copy of the original CMS decision letter identifying the initial deficiency and notification of the payment reduction *as well as* the CMS decision related to the reconsideration request.
- **Date of Final Determination:** Identify the date that the CMS reconsideration decision letter was issued.
- **Type of Quality Reporting Program:** This description should be identified within the decision letter received. Examples of CMS' quality reporting programs and initiatives, along with associated legislative mandates, are identified at https://mmshub.cms.gov/about-quality/quality-at-CMS/quality-programs.

Appeal Issue(s)

- **Issue Title and Statement:** The issue title may be identified as "Quality Reporting Program Payment Reduction" in the data field. You must also upload a more comprehensive document that describes the following components:
  - the controlling authority (e.g., specific regulation, Federal Register issuance, manual provision, or Ruling) for the Quality Reporting Program,
  - why the payment adjustment is incorrect,
  - how the payment should be determined differently,
  - the reimbursement effect, and
  - the basis for jurisdiction before the PRRB (*see* PRRB Rule 4).
- **Protested Item:** This item is not applicable to Quality Reporting Program appeals and should be marked "No" and an upload is not necessary.
- **Audit Adjustment Number:** This item is not applicable to Quality Reporting Program appeals. Please enter "None" in the data field though an upload is required. You may include a document stating that there are no audit adjustments or you may include a copy of the decision letter previously provided.

- **Amount in Controversy:** You must estimate the financial impact of the payment reduction and include a dollar amount in the data field. You must upload a copy of the calculation used to determine the amount in controversy, including an explanation of any factors used to calculate this estimate. Please remember that the calculation should only be based upon your Medicare patient population.
- **Other Documents (Optional):** You may include any other correspondence or documentation that you believe the Board may find helpful in the review of your case.

9. Is there another way to appeal the Quality Reporting Payment Reduction Decision?

A. If the amount in controversy is $10,000 or more, you must file your appeal with the PRRB.

If the amount in controversy is at least $1,000, but less than $10,000, then Federal Specialized Services ("FSS") will manage the dispute as an Intermediary Hearing. Requests for an Intermediary Hearing should be sent electronically to intermediary@fssappeals.com.

10. Who may I contact if I have questions regarding my appeal?

B. If you have OH CDMS registration or system questions, please contact the OH CDMS Help Desk at 1-833-783-8255 or by email at Helpdesk_OHCDMS@cms.hhs.gov.

Inquiries about routine procedural or logistical matters should be directed to the Board Advisor (see the Contacts tab within OH CDMS). Or, if an Advisor has not yet been designated, please contact the Office of Hearings staff via its main telephone line at 410-786-2671 or by email at PRRB@cms.hhs.gov.

However, please note that all correspondence related to specific PRRB cases must be filed electronically via OH CDMS. See PRRB Rule 2.1.1. Also, it is improper to communicate with the Board or the Office of Hearings staff concerning the merits of a case unless all parties are included in the communication. *See* PRRB Rule 40.

Record of Changes

Date	Description of Changes
8/17/2022	Initial issuance of FAQs.
1/24/2024	Updates to CMS.gov URL (*i.e.,* uniform resource locator) links, which were changed following the CMS.gov website design in September 2023. Clarification of mandatory electronic filing in Q10 with reference to PRRB Rule 2.1.1.

Table 1: Record of Changes