

as natural or other catastrophe, weather conditions, fire, or furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner.

(3) If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.

(4) For purposes of paragraph (d) of this section, the reviewing entity is deemed to also include—

(i) The contractor, if the contractor hearing officer(s) is not yet appointed (or none is currently presiding); and

(ii) The Office of the Attorney Advisor.

[39 FR 34515, Sept. 26, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 48 FR 39834, Sept. 1, 1983; 48 FR 45773, Oct. 7, 1983; 49 FR 322, Jan. 3, 1984; 49 FR 23013, June 1, 1984; 51 FR 34793, Sept. 30, 1986; 61 FR 63749, Dec. 2, 1996; 73 FR 30243, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 80 FR 70597, Nov. 13, 2015; 85 FR 59018, Sept. 18, 2020]

§ 405.1803 Contractor determination and notice of amount of program reimbursement.

(a) *General requirement.* Upon receipt of a provider's cost report, or amended cost report where permitted or required, the contractor must within a reasonable period of time (as specified in § 405.1835(c)(1)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the contractor's final determination of the total amount of reimbursement due the provider. The contractor must include the following information in the notice, as appropriate:

(1) *Reasonable cost.* The notice must—

(i) Explain the contractor's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost report; and

(ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

(2) *Prospective payment.* With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (see part 412 of this chapter), the contractor must include in the notice its determination of the total amount of the payments due the hospital under that system for the cost reporting period covered by the notice. The notice must explain (with appropriate use of the applicable money amounts) any difference in the amount determined to be due, and the amounts received by the hospital during the cost reporting period covered by the notice.

(3) *Hospice caps.* With respect to a hospice, the reporting period for the cap calculation is the cap year; and the contractors' determination of program reimbursement letter, which provides the results of the inpatient and aggregate cap calculations, shall serve as a notice of program reimbursement. The time period for filing cap appeals begins with receipt of the determination of program reimbursement letter.

(b) *Requirements for contractor notices.* The contractor must include in each notice appropriate references to law, regulations, CMS Rulings, or program instructions to explain why the contractor's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to contractor or Board hearing (see §§ 405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of receipt of the notice.

(c) *Use of notice as basis for recoupment of overpayments.* The contractor's determination contained in its notice is the basis for making the retroactive adjustment (required by § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including recoupment under § 405.373 from ongoing payments to the provider of any overpayments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

§ 405.1804

(d) *Effect of certain final agency decisions and final court judgments; audits of self-disallowed and other items.* (1) This paragraph applies to the following administrative decisions and court judgments:

(i) A final hearing decision by the contractor (as described in § 405.1833 of this subpart) or the Board (as described in § 405.1871(b) of this subpart).

(ii) A final decision by a CMS reviewing official (as described in § 405.1834(f)(1) of this subpart) or the Administrator (as described in § 405.1875(e)(4) of this subpart) following review of a hearing decision by the contractor or the Board, respectively.

(iii) A final, non-appealable judgment by a court on a Medicare reimbursement issue that the court rendered in accordance with jurisdiction under section 1878 of the Act (as described in §§ 405.1842 and 405.1877 of this subpart).

(2) For any final agency decision or final court judgment specified in paragraph (d)(1) of this section, the contractor must promptly, upon notification from CMS—

(i) Determine the effect of the final decision or judgment on the contractor determination for the cost reporting period at issue in the decision or judgment; and

(ii) Issue any revised contractor determination, and make any additional program payment, or recoup or offset any program payment (as described in § 405.371 of this subpart), for the period that may be necessary to implement the final decision or judgment on the specific matters at issue in the decision or judgment.

(3) CMS may require the contractor to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised contractor determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

(4) For any final settlement agreement, whether for an appeal to the contractor hearing officer(s) or the Board or for a civil action before a court, the contractor must implement the settlement agreement in accordance with paragraphs (d)(2) and (d)(3) of this section, unless a particular administrative

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or judicial settlement agreement provides otherwise.

[48 FR 39834, Sept. 1, 1983, as amended at 49 FR 322, Jan. 3, 1984; 51 FR 34793, Sept. 30, 1986; 61 FR 63748, Dec. 2, 1996; 73 FR 30244, May 23, 2008; 74 FR 39412, Aug. 6, 2009; 80 FR 70597, Nov. 13, 2015]

§ 405.1804 Matters not subject to administrative and judicial review under prospective payment.

Neither administrative nor judicial review is available for controversies about the following matters:

(a) The determination of the requirement, or the proportional amount, of the budget neutrality adjustment in the prospective payment rates required under section 1886(e)(1) of the Social Security Act.

(b) The establishment of—

(1) Diagnosis related groups (DRGs);

(2) The methodology for the classification of inpatient discharges within the DRGs; or

(3) Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.

[49 FR 322, Jan. 1, 1984, as amended at 78 FR 75195, Dec. 10, 2013]

§ 405.1805 Parties to contractor determination.

The parties to the contractor's determination are the provider and any other entity found by the contractor to be a related organization of the provider under § 413.17 of this chapter.

[48 FR 39835, Sept. 1, 1983, as amended at 51 FR 34793, Sept. 30, 1986]

§ 405.1807 Effect of contractor determination.

The determination shall be final and binding on the party or parties to such determination unless:

(a) A contractor hearing is requested in accordance with § 405.1811 and a contractor hearing decision rendered in accordance with § 405.1831; or

(b) The contractor determination is revised in accordance with § 405.1885; or

(c) A Board hearing is requested in accordance with § 405.1835 and a hearing decision rendered pursuant thereto.