

(2) When the hospital requests review, and the QIO concurs with the hospital's discharge determination, a hospital may not charge a beneficiary until the date specified by the QIO in accordance with 405.1206(f)(4).

(b) *Procedures hospital must follow.* (1) The hospital must (acting directly or through its utilization review committee) notify the beneficiary (or his or her representative) that it has requested that review.

(2) The hospital must supply any pertinent information the QIO requires to conduct its review and must make it available by phone or in writing, by close of business of the first full working day immediately following the day the hospital submits the request for review.

(c) *Procedures the QIO must follow.* (1) The QIO must notify the hospital that it has received the request for review and must notify the hospital if it has not received all pertinent records.

(2) The QIO must examine the pertinent records pertaining to the services.

(3) The QIO must solicit the views of the beneficiary in question.

(4) The QIO must make a determination and notify the beneficiary, the hospital, and physician within 2 working days of the hospital's request and receipt of any pertinent information submitted by the hospital.

(d) *Notice of an expedited determination.* (1) When a QIO issues an expedited determination as stated in paragraph (c)(4) of this section, it must notify the beneficiary, physician, and hospital of its decision, by telephone and subsequently in writing.

(2) A written notice of the expedited initial determination must contain the following:

- (i) The basis for the determination;
- (ii) A detailed rationale for the determination;
- (iii) A statement explaining the Medicare payment consequences of the expedited determination and date of liability, if any; and
- (iv) A statement informing the beneficiary of his or her appeal rights and the timeframe for requesting an appeal.

(e) *Effect of an expedited determination.* The expedited determination under this section is binding upon the bene-

ficiary, physician, and hospital, except in the following circumstances:

(1) *When a beneficiary remains in the hospital.* If the beneficiary is still an inpatient in the hospital and is dissatisfied with this determination, he or she may request a reconsideration according to the procedures described in § 405.1204. The procedures described in § 405.1204 will apply to reconsiderations requested under this section. If the beneficiary does not make a request in accordance with § 405.1204(b)(1), the timeframes described in § 405.1204(c)(3), the escalation procedures described in § 405.1204(c)(5), and the coverage rule described in § 405.1204(f) will not apply.

(2) *When a beneficiary is no longer an inpatient in the hospital.* If the beneficiary is no longer an inpatient in the hospital and is dissatisfied with this determination, this determination is subject to the general claims appeal process.

[69 FR 69624, Nov. 26, 2004, as amended at 71 FR 68722, Nov. 27, 2006]

Subparts K–Q [Reserved]

Subpart R—Provider Reimbursement Determinations and Appeals

AUTHORITY: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

SOURCE: 39 FR 34515, Sept. 26, 1974, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

EDITORIAL NOTE: Nomenclature changes to subpart R of part 405 appear at 79 FR 55031, Aug. 22, 2014.

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

Administrator means the Administrator or Deputy Administrator of CMS.

Administrator review means that review provided for in section 1878(f) of the Act (42 U.S.C. 1395oo(f)) and § 405.1875.

Board means the Provider Reimbursement Review Board established in

accordance with section 1878 of the Act (42 U.S.C. 1395oo) and §405.1845.

Board hearing means that hearing provided for in section 1878(a) of the Act (42 U.S.C. 1395oo(a)), and §405.1835.

CMS reviewing official means the reviewing official provided for in §405.1834.

CMS reviewing official procedure means the review provided for in §405.1834.

Contractor determination means the following:

(1) With respect to a provider of services that has filed a cost report under §§413.20 and 413.24 of this chapter, the term means a final determination of the amount of total reimbursement due the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to §405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

(4) For purposes of §405.376 concerning claims collection activities, the term does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim, against a provider or physician or other supplier.

Contractor hearing means that hearing provided for in §405.1809.

Contractor hearing officer(s) means the hearing officer or panel of hearing officers provided for in §405.1817.

Date of receipt means the date a document or other material is received by either of the following:

(1) *A party or an affected nonparty.* A party or an affected nonparty, such as CMS, involved in proceedings before a reviewing entity.

(i) As applied to a party or an affected nonparty, the phrase "date of receipt" in this definition is synonymous with the term "notice," as that term is used in section 1878 of the Act and in this subpart.

(ii) For purposes of a contractor hearing, if no contractor hearing officer is appointed (or none is currently presiding), the date of receipt of materials sent to the contractor hearing officer (as permitted under paragraph (d) of this section) is presumed to be, as applicable, the date that the contractor stamps "Received" on the materials, or the date of electronic delivery.

(iii) The date of receipt by a party or affected nonparty of documents involved in proceedings before a reviewing entity is presumed to be 5 days after the date of issuance of a contractor notice or a reviewing entity document. 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.

(2) *A reviewing entity.* For purposes of this definition, a reviewing entity is deemed to include the Office of the Attorney Advisor. The determination as to the date of receipt by the reviewing entity to which the document or other material was submitted (as permitted under paragraph (d) of this section) is final and binding as to all parties to the appeal. The date of receipt of documents by a reviewing entity is presumed to be, as applicable, one of the following dates:

(i) Of delivery where the document or material is transmitted by a nationally-recognized next-day courier (such as the United States Postal Service's Express Mail, Federal Express, UPS, DHL, etc.).

(ii) Stamped “Received” by the reviewing entity on the document or other submitted material (where a nationally-recognized next-day courier is not employed). This presumption, which is otherwise conclusive, may be overcome if it is established by clear and convincing evidence that the document or other material was actually received on a different date.

(iii) Of electronic delivery. *In writing* or *written* means a hard copy or electronic submission (subject to the restrictions in paragraph (d) of this section), as applicable throughout this subpart.

Reviewing entity means the contractor hearing officer(s), a CMS reviewing official, the Board, or the Administrator.

(b) *General rules*—(1) *Providers*. In order to be paid for covered services furnished to Medicare beneficiaries, a provider must file a cost report with its contractor as specified in § 413.24 of this chapter. For purposes of this subpart, the term “provider” includes a hospital (as described in part 482 of this chapter), hospice program (as described in § 418.3 of this chapter), critical access hospital (CAH), comprehensive outpatient rehabilitation facility (CORF), renal dialysis facility, Federally qualified health center (FQHC), home health agency (HHA), rural health clinic (RHC), skilled nursing facility (SNF), and any other entity included under the Act. (FQHCs and RHCs are providers, for purposes of this subpart, effective with cost reporting periods beginning on or after October 1, 1991).

(2) *Other nonprovider entities participating in Medicare Part A*. (i) Providers of services, as well as, other entities (including, but not limited to health maintenance organizations (HMOs) and competitive medical plans (CMPs) (as described in § 400.200 of this chapter)) may participate in the Medicare program, but do not qualify as providers under the Act or this subpart.

(ii) Some of these nonprovider entities are required to file periodic cost reports and are paid on the basis of information furnished in these reports. Except as provided at § 413.420(g) of this chapter, these nonprovider entities may not obtain a contractor hearing or

a Board hearing under section 1878 of the Act or this subpart.

(iii) Some other hearing will be available to these nonprovider entities, if the amount in controversy is at least \$1,000.

(iv) For any nonprovider hearing, the procedural rules for a Board hearing set forth in this subpart are applicable to the maximum extent possible.

(c) *Effective dates*. (1) Except as provided in paragraphs (c)(2) and (c)(3) of this section or in § 405.1885(e), this subpart applies to all cost reporting periods ending on or after December 31, 1971, for which reimbursement may be made on a reasonable cost basis.

(2) Sections 405.1835 to 405.1877 apply only to cost reporting periods ending on or after June 30, 1973, for which reimbursement may be made on a reasonable cost basis.

(3) With respect to hospitals under the prospective payment system (see part 412 of this chapter), the appeals procedures in §§ 405.1811 to 405.1877 that apply become applicable with the hospital’s first cost reporting period beginning on or after October 1, 1983.

(d) *Method for submissions and calculating time periods and deadlines*. Except for subpoena requests being sent to a nonparty under § 405.1857(c), the reviewing entity may prescribe the method(s) by which a party must make a submission, including the requirement to use an electronic filing system for submission of documents. Such methods or instructions apply to any period of time or deadline prescribed or allowed under this subpart (for example, requests for appeal under §§ 405.1811(b), 405.1835(b), and 405.1837(c) and (e)) or authorized by a reviewing entity. In computing any period of time or deadline prescribed or allowed under this subpart or authorized by a reviewing entity the following principles are applicable:

(1) The day of the act, event, or default from which the designated time period begins to run is not included.

(2) Each succeeding calendar day, including the last day, is included in the designated time period, except that, in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary

circumstances beyond its control such 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; 87 FR 72284, Nov. 23, 2022]

§ 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 reim-

bursement 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

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any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

(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

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paragraphs (d)(2) and (d)(3) of this section, unless a particular administrative 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.

§ 405.1809 Contractor hearing procedures.

(a) *Hearings.* Each contractor must establish and maintain written procedures for contractor hearings, in accordance with the regulations in this subpart, for resolving issues that may arise between the contractor and a provider concerning the amount of reasonable cost reimbursement, or prospective payment due the provider (except as provided in § 405.1804) under the Medicare program. The procedures must provide for a hearing on the contractor determination contained in the notice of program reimbursement (§ 405.1803), if the provider files a timely request for a hearing.

(b) *Amount in controversy.* In order for a contractor to grant a hearing, the following dates and amounts in controversy apply:

(1) For cost reporting periods ending prior to June 30, 1973, the amount of program reimbursement in controversy must be at least \$1000.

(2) For cost reporting periods ending on or after June 30, 1973, the amount of program reimbursement in controversy must be at least \$1000 but less than \$10,000.

[48 FR 39835, Sept. 1, 1983, as amended at 49 FR 323, Jan. 1, 1984]

§ 405.1811 Right to contractor hearing; contents of, and adding issues to, hearing request.

(a) *Right to hearing on final contractor determination.* A provider (but no other individual, entity, or party) has a right to a contractor hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—

(1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice pursuant to § 405.1803. Exception: If a final contractor determination is reopened under § 405.1885, any review by the contractor hearing officer must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1832(c)(2)(i)).

(2) The amount in controversy (as determined in accordance with § 405.1839) must be at least \$1,000 but less than \$10,000.

(3) Unless the provider qualifies for a good cause extension under § 405.1813, the date of receipt by the contractor of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

(b) *Contents of request for a contractor hearing on final contractor determination.* The provider's request for a contractor hearing under paragraph (a) of this section must be submitted in writing to the contractor, and the request must include the elements described in paragraphs (b)(1) through (b)(3) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the contractor hearing officer may dismiss with prejudice the appeal or take any other remedial action he or she considers appropriate.

(1) A demonstration that the provider satisfies the requirements for a contractor hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:

(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it allegedly does not have access to underlying information concerning the calculation of its payment); and

(ii) How and why the provider believes Medicare payment should be determined differently for each disputed item.

(iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement

sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

(3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

(c) *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a contractor hearing, as a single provider appeal, for specific items for a cost reporting period if—

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

(2) Unless the provider qualifies for a good cause extension under § 405.1813, the date of receipt by the contractor of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section); and

(3) The amount in controversy (as determined in accordance with § 405.1839) is at least \$1,000 but less than \$10,000.

(d) *Contents of request for a contractor hearing based on untimely contractor determination.* The provider's request for a contractor hearing under paragraph (c) of this section must be submitted in writing to the contractor, and the request must include the elements described in paragraphs (d)(1) through (d)(3) of this section. If the provider submits a hearing request that does not meet the requirements of para-

graph (d)(1), (d)(2), or (d)(3) of this section, the contractor hearing officer may dismiss with prejudice the appeal or take any other remedial action he or she considers appropriate.

(1) A demonstration that the provider satisfies the requirements for a contractor hearing as specified in paragraph (c) of this section.

(2) An explanation (for each specific item at issue) of the following:

(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of Medicare payment).

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.

(iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

(3) A copy of any documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (d)(1) and (d)(2) of this section.

(e) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the contractor hearing officer, only if—

(1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.

(2) The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.

(3) The contractor hearing officer receives the provider's request to add issues no later than 60 days after the

expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

[73 FR 30244, May 23, 2008, as amended at 79 FR 50349, Aug. 22, 2014; 79 FR 59680, Oct. 3, 2014; 80 FR 70597, Nov. 13, 2015; 85 FR 59018, Sept. 18, 2020]

§ 405.1813 Good cause extension of time limit for requesting a contractor hearing.

(a) A request for a contractor hearing that is received by the contractor after the applicable 180-day time limit prescribed in § 405.1811(a)(3) or § 405.1811(c)(2) must be dismissed by the contractor hearing officer(s), except that the hearing officer(s) may extend the time limit upon a good cause showing by the provider.

(b) The contractor hearing officer(s) may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably have been expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the contractor hearing officer(s) within a reasonable time (as determined by the contractor hearing officer(s) under the circumstances) after the expiration of the applicable 180-day limit prescribed in § 405.1811(a)(3) or § 405.1811(c)(2).

(c) The contractor hearing officer(s) may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the contractor of the provider's extension request is later than 3 years after the date of the contractor or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the contractor hearing officer(s) must send prompt written notice to the provider, and send a copy to each party to the appeal. The notice must include an explanation of the reasons for the deci-

sion by the hearing officer(s) and the facts underlying the decision.

(e)(1) A decision denying an extension request under this section and dismissing the appeal is final and binding on the provider, unless the dismissal decision is reviewed by a CMS reviewing official in accordance with § 405.1834(b)(2)(i) of this subpart or reopened and revised by the contractor hearing officer(s) in accordance with § 405.1885 through § 405.1889 of this subpart. The contractor hearing officer(s) promptly sends the decision to the appropriate component of CMS (currently the Center for Medicare Management) (as specified in § 405.1834(b)(4) of this subpart).

(2) A decision granting an extension request under this section is not subject to immediate review by a CMS reviewing official (as described in § 405.1834(b)(3) of this subpart). Any decision may be examined during the course of CMS review of a final jurisdictional dismissal decision or a final hearing decision by the contractor hearing officer(s) (as described in §§ 405.1834(b)(2)(i) and 405.1834(b)(2)(ii) of this subpart).

[73 FR 30245, May 23, 2008, as amended at 80 FR 70598, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1814 Contractor hearing officer jurisdiction.

(a) *General rules.* (1) After a request for a contractor hearing is filed under § 405.1811 of this subpart, the contractor hearing officer(s) must do the following:

(i) Determine in accordance with paragraph (b) of this section whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.

(ii) Make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before conducting any of the following proceedings:

(A) Determining its authority to decide a legal question relevant to a matter at issue (as described in § 405.1829 of this subpart);

(B) Permitting discovery (as specified in § 405.1821 of this subpart); or

(C) Conducting a hearing (as specified in § 405.1819 of this subpart);

(2) The hearing officer(s) may revise a preliminary jurisdictional determination at any subsequent stage of the proceedings in an appeal, and it must promptly notify the parties of any revised determination.

(3) Under paragraph (c)(1) of this section, each contractor hearing decision (as described in § 405.1831 of this subpart) must include a final jurisdictional finding for each specific matter at issue in the appeal.

(4) If the hearing officer(s) finally determines it lacks jurisdiction over every specific matter at issue in the appeal, it issues a jurisdictional dismissal decision under paragraph (c)(2) of this section.

(5) Final jurisdictional findings and jurisdictional dismissal decisions by the hearing officer(s) are subject to the CMS reviewing official procedure in accordance with paragraph (d) of this section and § 405.1834(b)(2)(i) and (b)(2)(ii) of this subpart.

(b) *Criteria.* Except for the amount in controversy requirement, the jurisdiction of the contractor hearing officer(s) to grant a hearing is determined separately for each specific matter at issue in the contractor or Secretary determination for the cost reporting period under appeal. The hearing officer(s) has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a contractor hearing under § 405.1811. Certain matters at issue are removed from the jurisdiction of the contractor hearing officer(s); these matters include, but are not limited to, the following:

(1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items and services are excluded from coverage under section 1862 of the Act and part 411 of the regulations. Review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act, and of subpart I of part 405 and subpart B of part 478, as applicable.

(2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in section 1886(d)(7) of the Act and § 405.1804 of this subpart.

(c) *Final jurisdictional findings, and jurisdictional dismissal decisions by contractor hearing officer(s).* (1) In issuing a hearing decision under § 405.1831 of this subpart, the contractor hearing officer(s) must make a final determination of its jurisdiction, or lack thereof, for each specific matter at issue in the hearing decision. Each contractor hearing decision must include specific findings of fact and conclusions of law as to the jurisdiction of the hearing officer(s), or lack thereof, to grant a hearing on each matter at issue in the appeal.

(2) If the hearing officer(s) finally determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a jurisdictional dismissal decision. Each jurisdictional dismissal decision by the hearing officer(s) must include specific findings of fact and conclusions of law explaining the determination that there is no jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the jurisdictional dismissal decision must be sent promptly to each party to the appeal.

(3) A jurisdictional dismissal decision by the contractor hearing officer(s) under paragraph (c)(2) of this section is final and binding on the parties, unless the decision is reviewed by a CMS reviewing official in accordance with § 405.1834 of this subpart or reopened and revised by the contractor hearing officer(s) in accordance with § 405.1885 through § 405.1889 of this subpart.

(d) *CMS reviewing official review.* Any finding by the contractor hearing officer as to whether it has jurisdiction to grant a hearing on a specific matter at issue in an appeal is not subject to further administrative review, except as provided in this paragraph. The contractor hearing officer's jurisdictional findings as to specific matters at issue in an appeal may be reviewed solely during the course of CMS reviewing official review of one of the contractor

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hearing officer decisions specified in § 405.1834(b)(2) of this subpart.

[73 FR 30245, May 23, 2008, as amended at 80 FR 70598, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1815 Parties to proceedings before the contractor hearing officer(s).

When a provider files a request for a contractor hearing in accordance with § 405.1811 of this subpart, the parties to all proceedings before the contractor hearing officer(s) are the provider and, if applicable, any other entity found by the contractor hearing officer(s) to be a related organization of the provider under the principles enunciated in § 413.17 of this chapter. The parties must be given reasonable notice of the time, date, and place of any contractor hearing. Neither the contractor nor CMS may be made a party to proceedings before the contractor hearing officer(s).

[73 FR 30246, May 23, 2008]

§ 405.1817 Hearing officer or panel of hearing officers authorized to conduct contractor hearing; disqualification of officers.

The contractor hearing provided for in § 405.1809 shall be conducted by a hearing officer or panel of hearing officers designated by the contractor. Such hearing officer or officers shall be persons knowledgeable in the field of health care reimbursement. The hearing officer or officers shall not have had any direct responsibility for the program reimbursement determination with respect to which a request for hearing is filed; no hearing officer (or officers) shall conduct a hearing in a case in which he is prejudiced or partial with respect to any party, or where he has any interest in the matter pending for determination before him. Notice of any objection which a party may have with respect to a hearing officer shall be presented in writing to such officer by the objecting party at the party's earliest opportunity. The hearing officer shall consider the objection and shall, at his discretion, either proceed in the conduct of the hearing or withdraw. If the hearing officer does not withdraw, the objecting party may, after the hearing, present his objec-

tions to an executive official of the contractor, who shall rule promptly on the objection.

§ 405.1819 Conduct of contractor hearing.

The hearing shall be open to all parties thereto (see § 405.1815) and to representatives of the contractor and of the Centers for Medicare & Medicaid Services (see § 405.1815). The hearing officer(s) shall inquire fully into all of the matters at issue and shall receive into evidence the testimony and any documents which are relevant and material to such matters. If the hearing officer(s) believes that there is relevant and material evidence available which has not been presented at the hearing, he (they) may, at any time prior to the sending of notice of the decision, reopen the hearing record for the receipt of such evidence. The order in which the evidence and the allegations shall be presented and the conduct of the hearing shall be at the discretion of the hearing officer(s).

[39 FR 34515, Sept. 26, 1974, as amended at 85 FR 59019, Sept. 18, 2020]

§ 405.1821 Prehearing discovery and other proceedings prior to the contractor hearing.

(a) *Discovery rule: Time limits.* (1) Limited prehearing discovery may be permitted by the contractor hearing officer(s) upon request of a party, provided the request is timely and the hearing officer(s) makes a preliminary finding of its jurisdiction over the matters at issue in accordance with § 405.1814(a) of this subpart.

(2) A prehearing discovery request is timely if the request by a party is served no later than 120 days before the initially scheduled starting date of the contractor hearing, unless the contractor hearing officer(s) extends the time for requesting discovery.

(3) In the absence of a specific schedule for responses set by the contractor hearing officer(s), responses to interrogatories and requests for production of documents are due according to the schedule agreed upon by the party serving discovery and the party to which the discovery is directed. Responses by a party to interrogatories

or requests for production of documents must be served no later than 45 days before the initially scheduled start of the contractor hearing, unless the contractor hearing officer(s) orders otherwise. Responses by a nonparty to requests for production of documents must be served no later than 75 days after the date the requests were served on the nonparty, unless the party requesting the documents and the nonparty to which the requests are directed agree on a different time for responding, or unless the contractor hearing officer(s) extends the time for responding.

(4) Before ruling on a request to extend the time for requesting discovery or for responding to discovery, the hearing officer(s) must give the other parties to the appeal and any nonparty subject to a discovery request a reasonable period to respond to the extension request.

(5) If the extension request is granted, the hearing officer(s) sets a new deadline and has the discretion to reschedule the hearing date.

(b) *Discovery criteria*—(1) *General rule.* The contractor hearing officer(s) may permit discovery of a matter that is relevant to the specific subject matter of the contractor hearing, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate. In determining whether to permit discovery, and in fixing the scope and limits of any discovery, the hearing officer(s) uses the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence for guidance.

(2) *Limitations on discovery.* Any discovery before the contractor hearing officer(s) is limited as follows:

(i) A party may request of another party, or of a nonparty other than CMS, HHS or any Federal agency, the reasonable production of documents for inspection and copying.

(ii) A party may request another party to respond to a reasonable number of written interrogatories.

(iii) A party may not request admissions, take oral or written depositions, or take any other form of discovery not permitted under this section.

(c) *Discovery procedures. Rights of nonparties: Motions to compel or for protective order.* (1) A party may request discovery of another party to the proceedings before the contractor hearing officer(s) or of a nonparty other than CMS, HHS or other Federal agency. Any discovery request filed with the contractor hearing officer(s) must be sent promptly to the party or nonparty from which the discovery is requested, and to any other party to the contractor hearing (as described in § 405.1815 of this subpart).

(2) If a discovery request is made of a nonparty to the contractor hearing, the nonparty has the rights any party has in responding to a discovery request. The rights of the nonparty include, but are not limited to, the right to select and use any attorney or other representative, and to submit discovery responses, objections, or motions to the hearing officer(s).

(3) Each party and nonparty is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty.

(i) A party may submit to the contractor hearing officer(s) a motion to compel discovery that is permitted under this section, and a motion for a protective order regarding any discovery request may be submitted to the hearing officer(s) by a party or nonparty.

(ii) Any motion to compel or for protective order must include a self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute. A self-sworn declaration describing efforts to resolve or narrow a discovery dispute also must be included with any response to a motion to compel or for a protective order.

(iii) The hearing officer(s) must—

(A) Decide the motion in accordance with this section and any prior discovery ruling; and

(B) Issue and send to each party and any affected nonparty a discovery ruling that grants or denies the motion to compel or for protective order in whole or in part; if applicable the discovery ruling must specifically identify any part of the disputed discovery request

upheld and any part rejected, and impose any limits on discovery the hearing officer(s) finds necessary and appropriate. Nothing in this section authorizes the contractor hearing officer to compel any action from the Secretary or CMS.

(d) *Reviewability of discovery or disclosure rulings*—(1) *General rule*. A discovery ruling issued in accordance with paragraph (c)(3) of this section, or a disclosure ruling (such as one issued at a hearing), is not subject to immediate review by a CMS official (as described in § 405.1834(b)(3) of this subpart). A discovery ruling may be examined solely during the course of CMS review under § 405.1834 of this subpart of a jurisdictional dismissal decision (as described in § 405.1814(c)(2) of this subpart) or a hearing decision (as described in § 405.1831 of this subpart) by the contractor hearing officer(s).

(2) *Exception*. To the extent a ruling authorizes discovery or disclosure of a matter for which an objection based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before the contractor hearing officer(s), that portion of the discovery or disclosure ruling may immediately be reviewed by a CMS reviewing official in accordance with § 405.1834(b)(3).

(i) Upon notice to the contractor hearing officer that the provider intends to seek immediate review of a ruling, or that the contractor or other affected nonparty intends to suggest that the Administrator through the CMS reviewing official, take own motion review of the ruling, the contractor hearing officer stays all proceedings affected by the ruling.

(ii) The contractor hearing officer must determine, under the circumstances of a given case, the length of any stay, but in no event may the stay be less than 15 days.

(iii) If the Administrator through the CMS reviewing official—

(A) Grants a request for review, or takes own motion review, of a ruling, the ruling is stayed until such time as the CMS reviewing official issues a written decision that affirms, reverses, modifies, or remands the contractor hearing officer's ruling.

(B) Does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the ruling is not subject to immediate review.

(e) *Prehearing conference*. The contractor hearing officer(s) has discretion to schedule a prehearing conference. A prehearing conference may be conducted in person or telephonically, at the discretion of the contractor hearing officer(s). When a panel of contractor hearing officers is designated, the panel may appoint one or more hearing officers to act for the panel for any prehearing conference or any matter addressed at the conference.

[73 FR 30246, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1823 Evidence at contractor hearing.

Evidence may be received at the contractor hearing even though inadmissible under the rules of evidence applicable to court procedure. The hearing officer(s) shall give the parties opportunity for submission and consideration of facts and arguments, and during the course of the hearing, should in ruling upon admissibility of evidence, exclude irrelevant, immaterial, or unduly repetitious evidence. The hearing officer(s) shall render a final ruling on the admissibility of evidence.

§ 405.1825 Witnesses at contractor hearing.

The hearing officer(s) may examine the witnesses and shall allow the parties and their representatives to do so. Parties to the proceedings may also cross-examine witnesses.

§ 405.1827 Record of proceedings before the contractor hearing officer(s).

(a) The contractor hearing officer(s) must maintain a complete record of all proceedings in an appeal.

(b) The record consists of all documents and any other tangible materials timely submitted to the hearing officer(s) by the parties to the appeal and by any nonparty (as described in § 405.1821(c) of this subpart), along with all correspondence, rulings, orders, and decisions (including the final decision) issued by the hearing officer(s).

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(c) The record must include a complete transcription of the proceedings at any contractor hearing.

(d) A copy of the transcription must be made available to any party upon request.

[73 FR 30247, May 23, 2008]

§ 405.1829 Scope of authority of contractor hearing officer(s).

(a) The hearing officer(s) in exercising his authority must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as with CMS Rulings issued under the authority of the Administrator of the Centers for Medicare & Medicaid Services (as described in § 401.108 of this chapter), and with the general instructions issued by the Centers for Medicare & Medicaid Services in accordance with the Secretary's agreement with the contractor.

(b)(1) If the contractor hearing officer(s) has jurisdiction to conduct a hearing on the specific matters at issue under § 405.1811, and the legal authority to fully resolve the matters in a hearing decision (as described in § 405.1831 of this subpart), the hearing officer(s) must affirm, modify, or reverse the contractor's findings on each specific matter at issue in the contractor or Secretary determination for the cost year under appeal.

(2) The contractor hearing officer(s) also may make additional revisions on specific matters regardless of whether the contractor considered the matters in issuing the contractor determination for the cost year, provided the hearing officer(s) does not consider or decide any specific matter for which it lacks jurisdiction (as described in § 405.1814(b) of this subpart) or which was not timely raised in the provider's hearing request.

(3) The authority of the contractor hearing officer(s) under this paragraph to make the additional revisions is limited to those revisions necessary to fully resolve a specific matter at issue if—

(i) The hearing officer(s) has jurisdiction to grant a hearing on the specific matter under §§ 405.1811 and 405.1814 of this subpart; and

(ii) The specific matter was timely raised in an initial request for a con-

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tractor hearing filed in accordance with § 405.1811(b) of this subpart or in a timely request to add issues to an appeal submitted in accordance with § 405.1811(c) of this subpart.

[39 FR 34515, Sept. 26, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 73 FR 30247, May 23, 2008]

§ 405.1831 Contractor hearing decision.

(a) If the contractor hearing officer(s) finds jurisdiction (as described in § 405.1814(a) of this subpart) and conducts a hearing, the contractor hearing officer(s) must promptly issue a written hearing decision.

(b) The contractor hearing decision must be based on the evidence from the contractor hearing (as described in § 405.1823 of this subpart) and other evidence as may be included in the record (as described in § 405.1827 of this subpart).

(c) The decision must include findings of fact and conclusions of law on jurisdictional issues (as described in § 405.1814(c)(1) of this subpart) and on the merits of the provider's reimbursement claims, and include appropriate citations to the record evidence and to the applicable law, regulations, CMS Rulings, and other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

(d) A copy of the decision must be sent promptly to the contractor, to each party and to the appropriate component of CMS (which currently is the Center for Medicare Management).

(e) When the contractor's denial of the relief that the provider seeks before the contractor hearing officer(s) was based on procedural grounds (for example, the alleged failure of the provider to satisfy a time limit), or was based on the alleged failure to supply adequate documentation to support the provider's claim, and the contractor hearing officer(s) rule(s) that the basis of the contractor's denial is invalid, the contractor hearing officer(s) remands to the contractor for the contractor to make a determination on the merits of the provider's claim.

[73 FR 30248, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1832 Contractor hearing officer review of compliance with the substantive reimbursement requirement of an appropriate cost report claim.

(a) *General.* In order to receive or potentially qualify for reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the contractor seeking reimbursement for a specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the contractor hearing officer(s) must address such questions in accordance with the procedures set forth in this section.

(b) *Summary of procedures—(1) Preliminary steps.* The contractor hearing officer(s) must give each party to the appeal an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence and legal argument (if any), the contractor hearing officer(s) must review such evidence and argument, and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter. In reaching such specific factual findings and legal conclusions, the contractor hearing officer(s) must follow the procedures set forth in § 413.24(j)(3) of this chapter for determining whether the provider's cost report included an appropriate claim for the specific item under appeal. The contractor hearing officer(s) must promptly give a copy of such written specific factual findings and legal conclusions to each party to the appeal, and such factual findings and legal conclusions must be included in the record of administrative proceedings for the appeal (as prescribed in § 405.1827).

(2) *Limits on contractor hearing officer(s) actions.* The contractor hearing officer(s)'s specific findings of fact and conclusions of law (in accordance with

paragraph (b)(1) of this section) must not be invoked or relied on by the contractor hearing officer(s) as a basis to deny, or decline to exercise, jurisdiction over a specific item or take any other of the actions specified in paragraph (c) of this section. Upon giving the parties to the appeal the contractor hearing officer(s)'s written specific factual findings and legal conclusions (pursuant to paragraph (b)(1) of this section) on the question of whether the provider's cost report included an appropriate cost report claim for the specific item under appeal, the contractor hearing officer(s) must proceed to issue one of the two types of overall decisions specified in paragraphs (d) and (e) of this section with respect to the specific item. If the contractor hearing officer(s) issues an overall contractor hearing decision (as specified in paragraph (d) of this section) regarding the specific item under appeal, the contractor hearing officer(s)'s written specific factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section) must be included in such overall contractor hearing decision regarding the specific item, along with the other matters that are required by the regulations for an overall contractor hearing decision. However, if the contractor hearing officer(s) issues an overall jurisdictional dismissal decision (as specified in paragraph (e) of this section) regarding the specific item under appeal, the contractor hearing officer(s)'s written specific factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section) must not be included in the overall jurisdictional dismissal decision regarding the specific item. The contractor hearing officer(s) may permit reimbursement for the specific item under appeal, as part of an overall contractor hearing decision, but such reimbursement may be permitted only to the extent authorized by paragraph (f) of this section.

(c) *Prohibition of certain types of decisions, orders, and other actions.* (1) If the contractor hearing officer(s) determines, in its findings of fact and conclusions of law (as prescribed by paragraph (b)(1) of this section), that the provider's cost report did not include an appropriate claim for the specific

item under appeal, the contractor hearing officer(s) may not—

(i) Deny jurisdiction over the specific item under appeal, based on (in whole or in part) the contractor hearing officer(s)'s factual findings and legal conclusions (reached under paragraph (b)(1) of this section);

(ii) Decline to exercise jurisdiction over the specific item under appeal, based on (in whole or in part) the contractor hearing officer(s)'s factual findings and legal conclusions (reached under paragraph (b)(1) of this section); or

(iii) Impose any sanction or take any other action against the interests of any party to the appeal except as provided in paragraph (f) of this section, based on (in whole or in part) the contractor hearing officer(s)'s factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section).

(2) Regardless of whether the contractor hearing officer(s) determines, in its findings of fact and conclusions of law (as prescribed by paragraph (b)(1) of this section), that the provider's cost report did or did not include an appropriate claim for the specific item under appeal, the contractor hearing officer(s) may not—

(i) Deny jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item. *Exception:* If the provider's appeal of the specific item is based on a reopening of such item (pursuant to § 405.1885) where the specific item is not revised, adjusted, corrected, or otherwise changed in a revised final contractor or Secretary determination, the contractor must deny jurisdiction over the specific item under appeal (as prescribed in §§ 405.1887(d) and 405.1889(b));

(ii) Decline to exercise jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor or Secretary determination under appeal, of an adjustment, revision, correction, or

other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item; or

(iii) Impose any sanction or take any other action against the interests of any party to the appeal except as provided in paragraph (f) of this section, based on (in whole or in part) the absence, in the final contractor or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item.

(d) *Contractor hearing decision must include any factual findings and legal conclusions under paragraph (b)(1) of this section.* If the contractor hearing officer(s) issues a hearing decision regarding the specific item under appeal (pursuant to § 405.1831), any specific findings of fact and conclusions of law by the contractor hearing officer(s) (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, must be included in such hearing decision along with the other matters prescribed by § 405.1831. The contractor hearing officer(s)'s factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section) about whether there was an appropriate cost report claim for the specific item under appeal are subject to the provisions of § 405.1833 just as those provisions apply to the other parts of the contractor hearing decision. If the contractor hearing officer(s) determines that the provider's cost report—

(1) Included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter), the contractor hearing decision also must address whether the other substantive reimbursement requirements for the specific item are also satisfied; or

(2) Did not include an appropriate claim for the specific item under appeal, the contractor hearing officer(s) has discretion whether or not to address in the contractor hearing decision whether the other substantive reimbursement requirements for the specific item are also satisfied.

(e) *Contractor jurisdictional dismissal decision must not include factual findings and legal conclusions under paragraph (b)(1) of this section.* If the contractor hearing officer(s) issues a jurisdictional dismissal decision regarding the specific item under appeal (in accordance with § 405.1814(c)), the contractor hearing officer(s)'s specific findings of fact and conclusions of law (in accordance with paragraph (b)(1) of this section) on the question of whether the provider's cost report included an appropriate claim for the specific item must not be included in such jurisdictional dismissal decision.

(f) Effects of the contractor hearing officer(s)'s factual findings and legal conclusions under paragraph (b)(1) of this section when part of a final contractor hearing decision. If the contractor hearing officer(s) determines, as part of a final and binding contractor hearing decision (pursuant to § 405.1833 and paragraphs (b)(1) and (d) of this section), that the provider's cost report—

(1) Included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter), the specific item is reimbursable in accordance with Medicare policy, but only if the contractor hearing officer(s) further determines in such final contractor hearing decision that all the other substantive reimbursement requirements for the specific item are also satisfied; or

(2) Did not include an appropriate cost report claim for the specific item under appeal, the specific item is not reimbursable, regardless of whether the contractor hearing officer(s) further determines in such final contractor hearing decision that the other substantive reimbursement requirements for the specific item are or are not satisfied.

[80 FR 70598, Nov. 13, 2015]

§ 405.1833 Effect of contractor hearing decision.

A contractor hearing decision issued in accordance with § 405.1831 of this subpart is final and binding on all parties to the contractor hearing and on the contractor, unless the hearing decision is reviewed by a CMS reviewing official in accordance with § 405.1834 of

this subpart or reopened and revised by the contractor hearing officer(s) in accordance with § 405.1885 through § 405.1889 of this subpart. Final contractor hearing decisions are subject to the provisions of § 405.1803(d) of this subpart.

[73 FR 30248, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1834 CMS reviewing official procedure.

(a) *Scope.* A provider that is a party to, and dissatisfied with, a final decision by the contractor hearing officer(s), upon submitting a request that meets the requirements of paragraph (c) of this section, is entitled to further administrative review of the decision, or the decision may be reviewed at the discretion of the Administrator. No other individual, entity, or party has the right to the review. The review is conducted on behalf of the Administrator by a designated CMS reviewing official who considers whether the decision of the contractor hearing officer(s) is consistent with the controlling legal authority (as described in § 405.1834(e)(1) of this subpart) and the evidence in the record. Based on the review, the CMS reviewing official issues a decision on behalf of the Administrator.

(b) *General rules.* (1) A CMS reviewing official may immediately review any final decision of the contractor hearing officer(s) as specified in paragraph (b)(2) of this section.

(i) Nonfinal decisions and other nonfinal actions by the contractor hearing officer(s) are not immediately reviewable, except as provided in paragraph (b)(3) of this section.

(ii) The CMS reviewing official exercises this review authority in response to a request from a provider party to the appeal that meets the requirements of paragraph (c) of this section or may exercise his or her discretion to take own motion review.

(2) A CMS reviewing official may immediately review the following:

(i) Any final jurisdictional dismissal decision by the contractor hearing officer(s), including any finding that the provider failed to demonstrate good cause for extending the time in which to request a hearing (as described in

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§§ 405.1813(e)(1) and 405.1814(c)(3) of this subpart).

(ii) Any final contractor hearing decision (as described in § 405.1831 of this subpart).

(iii) If the CMS reviewing official reviews a contractor hearing decision regarding a specific item, then the CMS reviewing official's review of such a contractor hearing decision will include, and any decision issued by the CMS reviewing official (under paragraph (e) of this section) will address, the contractor hearing officer(s)'s specific findings of fact and conclusions of law in such contractor hearing decision (as specified in § 405.1832(b)(1) and (d)) on the question of whether the provider's cost report included an appropriate claim for the specific item under appeal (as specified in § 413.24(j) of this chapter).

(3) Nonfinal decisions and other nonfinal actions by the contractor hearing officer(s) are not subject to the CMS reviewing official procedure until the contractor hearing officer(s) issues a final decision as specified in paragraph (b)(2) of this section (as described in §§ 405.1813(e)(2), 405.1814(c) and (d), and 405.1821(d)(1) of this subpart), except that the CMS reviewing official may immediately review a ruling, authorizing discovery or disclosure of a matter, where there is a claim of privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden.

(4) In order to facilitate the Administrator's exercise of this review authority, the contractor hearing officer(s) must promptly send copies of any decision specified in paragraph (b)(2) of this section or in § 405.1821(d)(2) of this subpart to the appropriate component of CMS (currently the Center for Medicare Management).

(i) All requests for review by a CMS reviewing official and all written submissions to a CMS reviewing official under paragraphs (c) and (d) of this section also must be sent to the appropriate component of CMS.

(ii) The appropriate CMS component examines each contractor hearing officer decision that is reviewable under paragraph (b)(2) of this section or § 405.1821(d)(2) of this subpart, along with any review requests and any other

submissions made by a party in accordance with the provisions of this section, in order to assist the Administrator's exercise of this review authority.

(c) *Request for review.* (1) A provider's request for review by a CMS reviewing official is granted if—

(i) The date of receipt by the appropriate CMS component of the review request is no later than 60 days after the date of receipt by the provider of the contractor hearing officer decision; or

(ii) The request seeks review of a decision listed in paragraph (b)(2) of this section, and the provider complies with the requirements of paragraph (c)(2) of this section.

(2) The provider must submit its request for review in writing, attach a copy of the contractor decision for which it seeks review and include a brief description of all of the following:

(i) Those aspects of the contractor hearing officer decision with which the provider is dissatisfied.

(ii) The reasons for the provider's dissatisfaction.

(iii) Any argument or record evidence the provider believes supports its position.

(iv) Any additional, extra-record evidence relied on by the provider, along with a demonstration that such evidence was improperly excluded from the contractor hearing (as described in § 405.1823 of this subpart).

(3) A provider request for immediate review of a contractor hearing officer ruling authorizing discovery or disclosure in accordance with paragraph (b)(3) of this section must—

(i) Be made as soon as practicable after the ruling is made, but in no event later than 5 business days after the date it received notice of the ruling; and

(ii) State the reason(s) why the ruling is in error and the potential harm that may be caused if immediate review is not granted.

(d) *Own motion review.* (1) The Administrator has discretion to take own motion review of a contractor hearing officer decision (regardless of whether the decision was favorable or unfavorable to the provider) or other reviewable action.

(2) In order to exercise this authority, the CMS reviewing official must, no later than 60 days after the date of the contractor hearing officer's decision, notify the parties and the contractor that he or she intends to review the contractor hearing officer decision or other reviewable action.

(3) In the notice, the CMS reviewing official identifies with particularity the issues that are to be reviewed, and gives each party (as described in § 405.1815 of this subpart) and affected nonparty a reasonable period to comment on the issues through a written submission complying with paragraph (c)(2) of this section.

(e) *Review procedure.* (1) In reviewing a contractor hearing officer decision specified in paragraph (b)(2) of this section, the CMS reviewing official must—

(i) Comply with all applicable law, regulations, and CMS Rulings (as described in § 401.108 of this chapter), and afford great weight to other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS;

(ii) Subject to paragraph (e)(1)(iii) of this section, limit the review to the record of the proceedings before the contractor hearing officer(s) (as described in § 405.1827 of this subpart) and any written submissions by the parties under paragraphs (c)(2) or (d) of this section; and

(iii) Consider additional, extra-record evidence only if he or she determines that the evidence was improperly excluded from the contractor hearing (as described in § 405.1823 of this subpart).

(2) Review of a contractor decision specified in paragraph (b)(2) of this section is limited to a hearing on the written record in accordance with paragraph (e)(1)(ii) of this section, unless the CMS reviewing official determines that—

(i) Additional, extra-record evidence may be considered in accordance with paragraph (e)(1)(iii) of this section;

(ii) An oral hearing is necessary for consideration of the extra-record evidence; and

(iii) It is not necessary or appropriate to remand the matter to the contractor hearing officer(s).

(3) Upon completion of the review of a contractor hearing decision specified in paragraph (b)(2) of this section, the CMS reviewing official issues a written decision that affirms, reverses, modifies, or remands the contractor hearing decision. A copy of the decision must be sent promptly to each party, to the contractor, and to the appropriate component of CMS (currently the Center for Medicare Management).

(f) *Effect of a decision: Remand.* (1) A decision of affirmation, reversal, or modification by the CMS reviewing official is final and binding on each party and the contractor. No further review or appeal of a decision is available, but the decision may be reopened and revised by a CMS reviewing official in accordance with § 405.1885 through § 405.1889 of this subpart. Decisions of a CMS reviewing official are subject to the provisions of § 405.1803(d) of this subpart. A decision by a CMS reviewing official remanding an appeal to the contractor hearing officer(s) for further proceedings under paragraph (f)(2) of this section is not a final decision.

(2) A remand to the contractor hearing officer(s) by the CMS reviewing official must—

(i) Vacate the contractor hearing officer decision;

(ii) Be governed by the same criteria that apply to remands by the Administrator to the Board under § 405.1875(f)(2) of this subpart, and require the contractor hearing officer(s) to take specific actions on remand; and

(iii) Result in the contractor hearing officer(s) taking the actions required on remand and issuing a new contractor hearing decision in accordance with §§ 405.1831 and 405.1833 of this subpart.

[73 FR 30248, May 23, 2008; 73 FR 49356 Aug. 21, 2008, as amended at 80 FR 70599, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1835 Right to Board hearing; contents of, and adding issues to, hearing request.

(a) Right to hearing on final contractor determination. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a

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final contractor or Secretary determination for the provider's cost reporting period, if—

(1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. *Exception:* If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).

(2) The amount in controversy (as determined in accordance with § 405.1839) must be \$10,000 or more.

(3) Unless the provider qualifies for a good cause extension under § 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 final contractor or Secretary determination.

(b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.

(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.

(2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:

(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct

because it does not have access to underlying information concerning the calculation of its payment).

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.

(iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

(3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

(4) With respect to a provider under common ownership or control, the name and address of its parent corporation, and a statement that—

(i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or

(ii) Such a pending appeal(s) exist(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

(c) *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of

receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

(2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section); and

(3) The amount in controversy (as determined in accordance with § 405.1839) is \$10,000 or more.

(d) *Contents of request for a Board hearing based on untimely contractor determination.* The provider's request for a Board hearing under paragraph (c) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (d)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (d)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.

(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (c) of this section.

(2) An explanation (for each specific item at issue) of the following:

(i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of Medicare payment).

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.

(iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

(3) A copy of any documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (d)(1) and (d)(2) of this section.

(4) With respect to a provider under common ownership or control, the name and address of its parent corporation, and a statement that meets all of the requirements of paragraphs (b)(4)(i) and (b)(4)(ii) of this section.

(e) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if—

(1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.

(2) The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.

(3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section.

[73 FR 30249, May 23, 2008; 73 FR 49356, Aug. 21, 2008, as amended at 79 FR 50350, Aug. 22, 2014; 79 FR 59680, Oct. 3, 2014; 80 FR 70599, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1836 Good cause extension of time limit for requesting a Board hearing.

(a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in § 405.1835(a)(3) or § 405.1835(c)(2) must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.

(b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or

strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) or § 405.1835(c)(2).

(c) The Board may not grant a request for an extension under this section if—

(1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or

(2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the contractor or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the Board must give prompt written notice to the provider, and send a copy of the notice to each party to the appeal. The notice must include a detailed explanation of the reasons for the decision by the Board and the facts underlying the decision.

(e)(1) If the Board denies an extension request and determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Board dismissal decision dismissing the appeal for lack of Board jurisdiction. This decision by the Board must be in writing and include the explanation of the extension request denial required under paragraph (d) of this section, in addition to specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal (as described in § 405.1840(c)). A copy of the Board's dismissal decision must be sent promptly to each party to the appeal (as described in § 405.1843).

(2) A Board dismissal decision under paragraph (e)(1) of this section is final and binding on the parties, unless the decision is reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(a)(2)(ii) and 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) This Board decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision, within the period.

(ii) A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart.

(3) The Administrator may review a Board decision granting an extension request solely during the course of an Administrator review of one of the Board decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2) of this subpart.

(4) A finding by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time for requesting a Board hearing is not subject to judicial review.

[73 FR 30250, May 23, 2008; 73 FR 49356, Aug. 21, 2008, as amended at 80 FR 70600, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1837 Group appeals.

(a) *Right to Board hearing as part of a group appeal: Criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the \$10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

(3) The amount in controversy is, in the aggregate, \$50,000 or more, as determined in accordance with § 405.1839 of this subpart.

(b) *Usage and filing of group appeals—*

(1) *Mandatory use of group appeals.* (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or

interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is \$50,000 or more in the aggregate, must bring the appeal as a group appeal.

(ii) One or more of the providers under common ownership or control may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the \$50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.

(iii) A group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control.

(iv)(A) Example 1: A, B, C and D are commonly owned providers that wish to appeal issue X. This issue was adjusted on A, B and C's CY 2004 cost reports, and on D's CY 2005 cost report. The amount in controversy is more than \$50,000 in the aggregate for providers A, B and C, and more than \$10,000 for provider D. Providers A, B and C must appeal issue X as a group appeal. Provider D may pursue an individual appeal to the Board under the procedures set forth in § 405.1835 of this subpart, or if the Board agrees, Provider D may join the group appeal. (If Provider D joins the group appeal, the calendar years in the group appeal would then be 2004 and 2005, and any provider related to Providers A through D by common ownership or control would be required to appeal issue X for its cost reporting period ending in 2004 or 2005 through the group appeal.)

(B) Example 2: A, B and C are commonly owned providers that wish to appeal issue X. This issue was adjusted on A, B and C's CY 2004 cost reports. The amount in controversy is less than \$50,000 in the aggregate for providers A, B and C (\$10,000 for A, \$10,000 for B and \$7,000 for C). Providers A, B and C cannot appeal issue X as a group appeal.

Provider A, if it wishes, and provider B, if it wishes, may pursue an individual appeal to the Board under the procedures set forth in § 405.1835 of this subpart. Provider C may not pursue an individual appeal to the Board, because the amount in controversy is less than \$10,000; however, it may pursue an appeal to the contractor under the procedures set forth in § 405.1811 of this subpart.

(2) *Optional group appeals.* (i) Two or more providers not under common ownership or control may bring a group appeal before the Board under this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under § 405.1835 of this subpart.

(ii) One or more of the providers bringing a group appeal under this paragraph may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for purposes of meeting the \$50,000 amount in controversy requirement, and, subject to the Board's discretion, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes, such as convenience.

(3) *Initiating a group appeal.* With respect to group appeals brought under paragraph (b)(1) of this section, one or more commonly owned or operated providers must make a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. Any group appeal filed by a single provider must be joined by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section. With respect to group appeals brought under paragraph (b)(2) of this section, two or more providers may submit—

(i) A written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section; or

(ii) A request to the Board in accordance with paragraph (e)(4) of this section that a specific matter at issue in

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a single provider appeal, filed previously under § 405.1835 of this subpart, be transferred from the single appeal to a group appeal.

(c) *Contents of request for a group appeal.* The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:

(1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.

(2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of—

(i) Why the provider believes Medicare payment is incorrect for each disputed item;

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and

(iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

(3) A copy of each final contractor or Secretary determination under appeal, and any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.

(4) A statement that—

(i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or

(ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

(d) *Board's preliminary response to group appeal hearing requests.* (1) Upon receipt of a group appeal hearing request, the Board must take any necessary ministerial steps.

(2) The steps, include, for example—

(i) Acknowledging the request;

(ii) Assigning a case number to the appeal; or

(iii) If applicable, transferring a specific matter at issue from a single provider appeal filed under § 405.1835 of this subpart to a group appeal filed under this section.

(e) *Group appeal procedures pending full formation of the group and issuance of a Board decision.* (1) A provider (or providers) may file a group appeal hearing request with the Board under this section before each provider member of the group identifies or complies with paragraphs (a)(1) and (a)(2) of this section, or before the group satisfies the \$50,000 amount in controversy requirement under paragraph (a)(3) of this section. Proceedings before the Board in any partially formed group appeal are subject to the provisions of paragraphs (e)(2), (e)(3), and (e)(4) of this section. The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed upon a notice in writing from the group that it is fully formed. Absent such a notice from the group, the Board may issue an order, requiring the group to demonstrate (within a period of not less than 15 days) that at least one commonly owned or controlled provider has preserved the issue for appeal by claiming the relevant item on its cost report or by self-disallowing the item, but has not yet received its final determination with respect to the item for a cost year that is within the same calendar year as that covered by the group appeal (or that it has received its final determination with respect to the item for that period, and is still within the time to request a hearing on the issue). The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed upon a notice in writing from the group that it is fully formed, or following an order from the Board that in its judgment, that the

group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

(2) The Board may make jurisdictional findings under § 405.1840 at any time, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings. The providers must include with the notice any additional information or documentary evidence that is required for group appeal hearing requests. The Board does not dismiss a group appeal hearing request for failure to meet the \$50,000 amount in controversy requirement until the Board has determined, in accordance with paragraph (e)(1) of this section, that the group is fully formed.

(3) If the Board makes a preliminary determination of jurisdiction to conduct a hearing as a group appeal under this section, the Board then takes any further actions in the appeal it finds to be appropriate under this subpart (as described in § 405.1840(a) of this subpart). The Board may take further actions, even though the providers in the appeal may wish to add other providers to the group in accordance with paragraph (e)(4) of this section. The Board must make separate jurisdictional findings for each cost reporting period added subsequently to the group appeal (as described in §§ 405.1837(a) and 405.1839(b) of this subpart).

(4) A provider may submit a request to the Board to join a group appeal any time before the Board issues one of the

decisions specified in § 405.1875(a)(2). By submitting a request, the provider agrees that, if the request is granted, the provider is bound by the Board's actions and decision in the appeal. If the Board denies a request, the Board's action is without prejudice to any separate appeal the provider may bring in accordance with § 405.1811, § 405.1835, or this section. For purposes of determining timeliness for the filing of any separate appeal and for the adding of issues to such appeal, the date of receipt of the provider's request to form or join the group appeal is considered the date of receipt for purposes of meeting the applicable 180-day period prescribed in § 405.1835(a)(3) or § 405.1835(c)(2).

(5)(i) Except as specified in paragraph (ii) of this paragraph, when a provider has appealed an issue through electing to form, or joining, a group appeal under the procedures set forth in this section, it may not subsequently request that the Board transfer that issue to a single provider appeal brought in accordance with § 405.1811 or § 405.1835 of this subpart.

(ii) *Exception.* When the Board determines that the requirements for a group appeal are not met (that is, when there has been a failure to meet the amount in controversy or the common issue requirement), it transfers the issue that was the subject of the group appeal to a single provider appeal (or appeals) for the provider (or providers) that meets (or meet) the requirements for a single provider appeal.

(f) *Limitations on group appeals.* (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may not add other questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).

(2) The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart—

(i) The Board must determine whether the appeal involves specific matters

at issue that raise more than one factual or legal question common to each provider; and

(ii) When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.

(g) *Issues not common to the group appeal.* A provider involved in a group appeal that also wishes to appeal a specific matter that does not raise a factual or legal question common to each of the other providers in the group must file a separate request for a single provider hearing in accordance with § 405.1811 or § 405.1835 of this subpart, or file a separate request for a hearing as part of a different group appeal under this section, as applicable.

[73 FR 30250, May 23, 2008, as amended at 80 FR 70600, Nov. 13, 2015]

§ 405.1839 Amount in controversy.

(a) *Single provider appeals.* (1) In order to satisfy the amount in controversy requirement under § 405.1811(a)(2) or § 405.1811(c)(3) for a contractor hearing or the amount in controversy requirement under § 405.1835(a)(2) or § 405.1835(c)(3) for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal would increase by at least \$1,000 but by less than \$10,000 for a contractor hearing, or by at least \$10,000 for a Board hearing, as applicable.

(2) *Aggregation of claims.* For purposes of satisfying the applicable amount in controversy requirement for a single provider appeal to the contractor or the Board, the provider may aggregate claims for additional program payment for more than one specific matter at issue, provided each specific claim and issue is for the same cost reporting period. Aggregation of claims from more than one cost reporting period to meet the applicable amount in controversy requirement is prohibited, even if a specific claim or issue in the appeal recurs for multiple cost years.

(b) *Group appeals.* (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least \$50,000.

(2) *Aggregation of claims.* (i) For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues.

(A) A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

(B) The single issue that is common to each provider may exist over different cost reporting periods.

(ii) For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

(c) *Limitations on change in Medicare reimbursement.* (1) In order to satisfy the applicable amount in controversy requirement for a single provider appeal or a group appeal, an appeal favorable to the provider(s) on all specific matters at issue in the appeal increases program reimbursement for the provider(s) in the cost reporting period(s) at issue by an amount that equals or exceeds the applicable amount in controversy threshold.

(2) The applicable amount in controversy requirement is not satisfied if the result of a favorable appeal decreases program reimbursement for the provider(s) in the cost reporting year(s) at issue in the appeal.

(3) Any effects that a favorable appeal might have on program reimbursement for the provider(s) in cost reporting period(s) not at issue in the appeal have no bearing on whether the amount in controversy requirement is satisfied for the cost year(s) at issue in the appeal.

(4) When a provider (or group of providers) has requested a hearing before a

contractor under § 405.1811 of this subpart, and the amount in controversy is subsequently determined to be at least \$10,000 (for example, due to a reassessment of the amount in controversy by the contractor hearing office or due to adding an issue), the appeal is transferred to the Board. The Board is not bound by any jurisdictional finding of the contractor hearing officer(s).

(5) When a provider or group of providers has requested a hearing before the Board under § 405.1835 or § 405.1837 of this subpart, and the amount in controversy changes to an amount less than the minimum for a Board appeal due to—

(A) The settlement or partial settlement of an issue, transfer of an issue to a group appeal, or the abandonment of an issue in an individual appeal, the change in the amount in controversy does not deprive the Board of jurisdiction.

(B) A more accurate assessment of the amount in controversy, the Board does not retain jurisdiction.

[73 FR 30252, May 23, 2008; 73 FR 49356, Aug. 21, 2008, as amended at 80 FR 70600, Nov. 13, 2015]

§ 405.1840 Board jurisdiction.

(a) *General rules.* (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.

(2) The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before conducting any of the following proceedings:

(i) Determining its authority to decide a legal question relevant to a matter at issue (as described in § 405.1842 of this subpart).

(ii) Permitting discovery (as described in § 405.1853 of this subpart).

(iii) Issuing a subpoena (as described in § 405.1857 of this subpart).

(iv) Conducting a hearing (as described in § 405.1845 of this subpart).

(3) The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised determination. Under paragraph (c)(1) of this section, each expedited judicial review (EJR) decision (as described in § 405.1842 of this subpart) and hearing decision (as described in § 405.1871 of this subpart) by the Board must include a jurisdictional finding for each specific matter at issue in the appeal.

(4) If the Board finally determines it lacks jurisdiction over every specific matter at issue in the appeal, the Board must issue a dismissal decision under paragraph (c)(2) of this section.

(5) Final jurisdictional findings and dismissal decisions by the Board under paragraphs (c)(1) and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.

(b) *Criteria.* Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. Certain matters at issue are removed from jurisdiction of the Board. These matters include, but are not necessarily limited to, the following:

(1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and part 411 of the regulations. Review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act and of subpart I of part 405 and subpart B of part 478 of the regulations, as applicable.

(2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in section 1886(d)(7) of the Act and § 405.1804 of this subpart.

(c) *Board's jurisdictional findings and jurisdictional dismissal decisions.* (1) In issuing an EJR decision under § 405.1842 of this subpart or a hearing decision under § 405.1871 of this subpart, as applicable, the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue in each contractor or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.

(2) Except as provided in §§ 405.1836(e)(1) and 405.1842(f)(2)(i), where the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a dismissal decision dismissing the appeal for lack of Board jurisdiction. The decision by the Board must include specific findings of fact and conclusions of law explaining the Board's determination that it lacks jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the Board's decision must be sent promptly to each party to the appeal (as described in § 405.1843).

(3) A dismissal decision by the Board under paragraph (c)(2) of this section is final and binding on the parties unless the decision is reversed, affirmed, modified or remanded by the Administrator under § 405.1875(a)(2)(ii) and § 405.1875(e) or § 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision. The Board decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies or remands that decision within that period. A final Board decision under paragraphs (c)(2) and (c)(3) of this section may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart.

(d) *Administrator and judicial review.* Any finding by the Board as to whether it has jurisdiction to grant a hearing

on a specific matter at issue in an appeal is not subject to further administrative and judicial review, except as provided in this paragraph. The Board's jurisdictional findings as to specific matters at issue in an appeal may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2) of this subpart, or during the course of judicial review of a final agency decision as described in § 405.1877(a) of this subpart, as applicable.

[73 FR 30253, May 23, 2008, as amended at 80 FR 70600, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1842 Expedited judicial review.

(a) *Basis and scope.* (1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

(3) The Administrator may review the Board's jurisdictional finding, but not the Board's authority determination.

(4) The provider has a right to seek EJR of the legal question under section 1878(f)(1) of the Act only if—

(i) The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue and a determination by the Board

that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete.

(b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.

(2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal, or the Board on its own motion may consider whether to grant EJR of a specific matter or matters under appeal. Under paragraph (c) of this section, the Board may initiate own motion consideration of its authority to decide a legal question only if the Board makes a preliminary finding that it has jurisdiction over the specific matter at issue to which the legal question is relevant. Under paragraphs (d) and (e) of this section, a provider may request a determination of the Board's authority to decide a legal question, but the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.

(c) *Board's own motion consideration*.

(1) If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, it may then consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue.

(2) The Board must initiate its own motion consideration by issuing a written notice to each of the parties to the appeal (as described in § 405.1843 of this subpart). The notice must—

(i) Identify each specific matter at issue for which the Board has made a finding that it has jurisdiction under

§ 405.1840(a) of this part, and for each specific matter, identify each relevant statutory provision, regulation, or CMS Ruling; and

(ii) Specify a reasonable period of time for the parties to respond in writing.

(3) After considering any written responses made by the parties to its notice of own motion consideration, the Board must determine whether it has sufficient information to issue an EJR decision for each specific matter and legal question included in the notice. If necessary, the Board may request additional information regarding its jurisdiction or authority from a party (or parties), and the Board must give any other party a reasonable opportunity to comment on any additional submission. Once the Board determines it needs no further information from the parties (or that any information has not been rendered timely), it must issue an EJR decision in accordance with paragraph (f) of this section.

(d) *Provider requests*. A provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal. A provider must submit a request in writing to the Board and to each party to the appeal (as described in § 405.1843 of this subpart), and the request must include—

(1) For each specific matter and question included in the request, an explanation of why the provider believes the Board has jurisdiction under § 405.1840 of this subpart over each matter at issue and no authority to decide each relevant legal question; and

(2) Any documentary evidence the provider believes supports the request.

(e) *Board action on provider requests*.

(1) If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue. The Board is required to make a determination of its authority to decide the legal question raised in a review request under paragraph (d)(1) of this section by issuing an EJR

decision no later than 30 days after receiving a complete provider request as defined in paragraph (e)(2) of this section.

(2) *Requirements of a complete provider request.* A complete provider request for EJR consists of the following:

(i) A request for an EJR decision by the provider(s).

(ii) All of the information and documents found necessary by the Board for issuing a decision in accordance with paragraph (f) of this section.

(3) *Board's response to provider requests.* After receiving a provider request for an EJR decision, the Board must review the request, along with any responses to the request submitted by other parties to the appeal (as described in §405.1843 of this subpart). The Board must respond to the provider(s) as follows:

(i) Upon receiving a complete provider request, issue an EJR decision in accordance with paragraph (f) of this section no later than 30 days after receipt of the complete provider request. If the Board does not issue a decision within that 30-day period, the provider has a right to file a complaint in Federal district court in order to obtain EJR over the specific matter(s) at issue.

(ii) If the provider has not submitted a complete request, issue no later than 30 days after receipt of the incomplete request a written notice to the provider describing in detail the further information that the provider must submit in order to complete the request.

(f) *Board's decision on EJR: Criteria for granting EJR.* Subject to paragraph (h)(3) of this section, the Board is required to issue an EJR decision following either the completion of the Board's own motion consideration under paragraph (c) of this section, or a notice issued by the Board in accordance with paragraph (e)(3)(i) of this section.

(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:

(i) The Board has jurisdiction to conduct a hearing on the specific matter

at issue in accordance with §405.1840 of this subpart.

(ii) The Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

(2) The Board's decision must deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if any of the following conditions are satisfied:

(i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue in accordance with §405.1840 of this subpart.

(ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.

(iii) The Board does not have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are met.

(3) A copy of the Board's decision must be sent promptly to—

(i) Each party to the Board appeal (as described in §405.1843 of this subpart) and

(ii) The Office of the Attorney Advisor.

(g) *Further review after the Board issues an EJR decision—(1) General rules.*

(i) Under §405.1875(a)(2)(iii) of this subpart, the Administrator may review, on his or her own motion, or at the request of a party, the jurisdictional component only of the Board's EJR decision.

(ii) Any review by the Administrator is limited to the question of whether there is Board jurisdiction over the specific matter at issue; the Administrator may not review the Board's determination of its authority to decide the legal question.

(iii) An EJR decision by the Board becomes final and binding on the parties unless the decision is reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(a)(2)(iii), 405.1875(e), and 405.1875(f) of this subpart no later than 60 days after the date of receipt by the provider of the Board's decision.

(iv) A Board decision is inoperative during the 60-day period for review by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision within that period.

(v) Any right of the provider to obtain EJR from a Federal district court is specified at paragraphs (g)(2) and (g)(3) of this section (when the Board issues a timely EJR decision) and paragraph (g)(4) of this section (in the absence of a timely Board decision).

(vi) A final Board decision under paragraph (f) of this section, and a final Administrator decision made upon review of a final Board decision (as described in § 405.1875(a)(2) and (e) of this subpart) may be reopened and revised in accordance with §§ 405.1885 through 405.1889 of this subpart.

(2) *Board grants EJR.* If the Board grants EJR, the provider may file a complaint in a Federal district court in order to obtain EJR of the legal question. If the Administrator renders, no later than 60 days after the date of receipt by the provider of the Board's decision granting EJR, a decision finding that the Board has no jurisdiction over the matter at issue, the Board's decision is nonfinal and the provider has no right to obtain judicial review based on the Board's decision (as described in § 405.1877(a)(3) and (b)(3) of this subpart).

(3) *Board denies EJR.* If the Board's decision denies EJR because the Board finds that it has the authority to decide the legal question relevant to the matter at issue, the Administrator may not review the Board's authority determination, and the provider has no right to obtain EJR. If the Board denies EJR based on a finding that it lacks jurisdiction over the specific matter, the provider has no right to obtain EJR unless—

(i) The Administrator renders timely a final decision reversing the Board,

finding the Board has jurisdiction over the matter at issue, and remanding to the Board; or

(ii) A court reverses the Board's or Administrator's decision as to jurisdiction, the Administrator remands to the Board, and the Board subsequently issues on remand from the Administrator an EJR decision granting EJR on the basis that it lacks the authority to decide the legal question.

(4) *No timely EJR decision.* The Board must issue an EJR decision no later than 30 days after the date of a written notice under paragraph (e)(3)(i) of this section, when the provider submits a complete request for EJR. If the Board does not issue an EJR decision within a 30-day period, the provider(s) has a right to seek EJR under section 1878(f)(1) of the Act.

(h) *Effect of final EJR decisions and lawsuits on further Board proceedings—*

(1) *Final decisions granting EJR.* If the final decision of the Board or the Administrator, as applicable (as described in §§ 405.1842(g)(1) and 405.1875(e)(4) of this subpart), grants EJR, the Board may not conduct any further proceedings on the legal question. The Board must dismiss—

(i) The specific matter at issue from the appeal.

(ii) The entire appeal if there are no other matters at issue that are within the Board's jurisdiction and can be fully decided by the Board.

(2) *Final decisions denying EJR.* If the final decision:

(i) Of the Board denies EJR solely on the basis that the Board determines it has the authority to decide the legal question relevant to the specific matter at issue, the Board must conduct further proceedings on the legal question and issue a decision on the matter at issue in accordance with this subpart.

Exception: If the provider(s) file(s) a lawsuit pertaining to the legal question, and for a period that is covered by the Board's decision denying EJR, the Board may not conduct any further proceedings under this subpart on the legal question or the matter at issue before the lawsuit is finally resolved.

(ii) Of the Board (or the Administrator) denies EJR on the basis that the Board lacks jurisdiction over the

specific matter at issue, the Board (or the Administrator) must, as applicable, dismiss the specific matter at issue from the appeal, or dismiss the appeal entirely if there are no other matters at issue that are within the Board's jurisdiction and can be fully decided by the Board. If only the specific matter(s) is dismissed from the appeal, judicial review may be had only after a final decision on the appeal is made by the Board or Administrator, as applicable (as described in §§ 405.1840(d) and 405.1877(a) of this subpart). If the Board or the Administrator, as applicable, dismisses the appeal entirely, the decision is subject to judicial review under § 405.1877(a) of this subpart.

(3) *Provider lawsuits.* (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

(ii) If the lawsuit is filed after a final EJR decision by the Board or the Administrator, as applicable (as described in §§ 405.1842(g)(1) and 405.1875(e)(4) of this subpart), on the legal question, the Board must carry out the applicable provisions of paragraphs (h)(1) and (h)(2) of this section in any pending Board appeal on the specific matter at issue.

(iii) If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.

[73 FR 30254, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1843 Parties to proceedings in a Board appeal.

(a)(1) When a provider files a request for a hearing before the Board in accordance with § 405.1835 or § 405.1837, the parties to all proceedings in the Board appeal include the provider, a contractor, and, where applicable, any

other entity found by the Board to be a related organization of the provider under the principles enunciated in § 413.17 of this chapter.

(2) All parties to a Board appeal are to familiarize themselves with the instructions for handling a Provider Reimbursement Review Board (PRRB) appeal, including any and all requirements related to the electronic/online filing of documents.

(b) Neither the Secretary nor CMS may be made a party to proceedings in a Board appeal.

(1) The Board may call as a witness any employee or officer of the Department of Health and Human Services or CMS having personal knowledge of the facts and the issues in controversy in an appeal.

(2) The regulations at 45 CFR Part 2 (Testimony by employees and production of documents in proceedings where the United States is not a party) apply as to whether such employee or officer will appear.

(c) A contractor may designate a representative from the Secretary or CMS, who may be an attorney, to represent the contractor in proceedings before the Board.

(d) Although CMS is not a party to proceedings in a Board appeal, there may be instances where CMS determines that the administrative policy implications of a case are substantial enough to warrant comment from CMS (as described in § 405.1863 of this subpart). CMS—

(1) May file *amicus curiae* (friend of the court) briefing papers with the Board in accordance with a schedule to be determined by the Board.

(2) Must promptly send copies of any documents filed with the Board to each party to the appeal.

(e) A nonparty other than CMS may seek leave from the Board to file *amicus curiae* briefing papers with the Board.

(f) The Board may exclude from the record all or part of an *amicus curiae* briefing paper. When the Board excludes from the record all or part of an *amicus curiae* briefing paper submitted by CMS, it states for the record its reason(s) in writing.

[73 FR 30256, May 23, 2008, as amended at 85 FR 59019, Sept. 18, 2020]

§ 405.1845 Composition of Board; hearings, decisions, and remands.

(a) The Board will consist of five members appointed by the Secretary. All shall be knowledgeable in the field of cost reimbursement. At least one shall be a certified public accountant. Two Board members shall be representative of providers of services.

(b) The term of office for Board members shall be 3 years, except that initial appointments may be for such shorter terms as the Secretary may designate to permit staggered terms of office. No member shall serve more than two consecutive 3-year terms of office. The Secretary shall have the authority to terminate a Board member's term of office for good cause.

(c) *Composition of the Board.* The Secretary designates one member of the Board as Chairperson. The Chairperson coordinates and directs the administrative activities of the Board and the conduct of proceedings before the Board. CMS provides administrative support for the Board. Under the direction of the Chairperson, the Board is solely responsible for the content of its decisions.

(d) *Quorum.* (1) The Board must have a quorum in order to issue one of the decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2)(i), (a)(2)(iii), and (a)(2)(iv), but a quorum is not required for other Board actions.

(2) Three Board members, at least one of whom is representative of providers, are required in order to constitute a quorum.

(3) The opinion of the majority of those Board members issuing a decision specified as final, or deemed as final by the Administrator, under § 405.1875(a)(2), constitutes the Board's decision.

(e) *Hearings.* The Board may conduct a hearing and issue a hearing decision (as described in § 405.1871 of this subpart) on a specific matter at issue in an appeal, provided it finds jurisdiction over the matter at issue in accordance with § 405.1840 of this part and determines it has the legal authority to fully resolve the issue (as described in § 405.1867 of this subpart).

(f) *Oral hearings.* (1) In accordance with paragraph (d) of this section, the

Board does not need a quorum in order to hold an oral hearing (as described in § 405.1851 of this subpart). The Chairperson of the Board may designate one or more Board members to conduct an oral hearing (where less than a quorum conducts the hearing). Because the presence of all Board members is not required at an oral hearing, the Board, at its discretion, may hold more than one oral hearing at a time.

(2) *Waiver of oral hearings.* With the contractor's agreement and the Board's approval, the provider (or, in the case of group appeals, the group of providers) and any related organizations (as described in § 405.1843(a) of this subpart) may waive any right to an oral hearing and stipulate that the Board may issue a hearing decision on the written record. An on-the-written-record hearing consists of all the evidence and written argument or comments submitted to the Board and included in the record (as described in § 405.1865 of this subpart).

(g) *Hearing decisions.* The Board's hearing decision must be based on the transcript of any oral hearing before the Board, any matter admitted into evidence at a hearing or deemed admissible evidence for the record (as described in § 405.1855 of this subpart), and any written argument or comments timely submitted to the Board (as described in § 405.1865 of this subpart).

(h) *Remands.* (1) Except as provided in paragraph (h)(3) of this section, a Board remand order may be reviewed solely during the course of Administrator review of one of the Board decisions specified in § 405.1875(a)(2) of this subpart, or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this part, as applicable.

(2) The Board may order a remand requiring specific actions of a party to the appeal. In ordering a remand, the Board must—

(i) Specify any actions required of the party and explain the factual and legal basis for ordering a remand;

(ii) Issue the remand order in writing; and

(iii) Send the remand order promptly to the parties and any affected nonparty, such as CMS, to the appeal.

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(3) A Board remand order is not subject to immediate Administrator review unless the Administrator determines that the remand order might otherwise evade his or her review (as described in § 405.1875(a)(2)(iv) of this subpart).

[39 FR 34515, Sept. 26, 1974, as amended at 41 FR 52051, Nov. 26, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 73 FR 30256, May 23, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1847 Disqualification of Board members.

No Board member shall join in the conduct of a hearing in a case in which he is prejudiced or partial with respect to any party or in which he has any interest in the matter pending for decision before him. Notice of any objection which a party may have with respect to a Board member shall be presented in writing to such Board member by the objecting party at its earliest opportunity. The Board member shall consider the objection and shall, in his discretion, either proceed to join in the conduct of the hearing or withdraw. If he does not withdraw, the objecting party may petition the Board, presenting its objection and reasons therefor, and be entitled to a ruling thereon before the hearing can proceed.

§ 405.1849 Establishment of time and place of hearing by the Board.

The Board shall fix the time and place for the hearing and shall send notice thereof to the parties' contact information on file, not less than 30 days prior to the scheduled time. Either on its own motion or for good cause shown by a party, the Board may, as appropriate, reschedule, adjourn, postpone, or reopen the hearing, provided that reasonable written notice is given to the parties.

[39 FR 34515, Sept. 26, 1974, as amended at 85 FR 59019, Sept. 18, 2020]

§ 405.1851 Conduct of Board hearing.

The Board hearing shall be open to the parties, to representatives of the Centers for Medicare & Medicaid Services, and to such other persons as the Board deems necessary and proper. The Board shall inquire fully into all of the matters at issue and shall receive into evidence the testimony of witnesses

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and any documents which are relevant and material to such matters. If the Board believes that there is relevant and material evidence available which has not been presented at the hearing, it may at any time prior to the issuing of the notice of the decision, reconvene the hearing for the receipt of such evidence. The order in which the evidence and the allegations shall be presented and the conduct of the hearing shall be at the discretion of the Board.

[39 FR 34515, Sept. 26, 1974, as amended at 85 FR 59019, Sept. 18, 2020]

§ 405.1853 Board proceedings prior to any hearing; discovery.

(a) *Preliminary narrowing of the issues.* Upon receiving notification that a request for a Board hearing is submitted, the contractor must—

(1) Promptly review both the materials submitted with the provider hearing request, and the information underlying each contractor or Secretary determination for each cost reporting period under appeal.

(2) Expeditiously attempt to join with the provider in resolving specific factual or legal issues and submitting to the Board written stipulations setting forth the specific issues that remain for Board resolution based on the review; and

(3) Ensure that the evidence it considered in making its determination, or, where applicable, the evidence the Secretary considered in making his or her determination, is included in the record.

(b) *Position papers.* (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.

(2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

(3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions.

(c) *Initial status conference.* (1) Upon review of the parties' position papers, one or more members of the Board may conduct an initial status conference. An initial status conference may be conducted in person or telephone, at the discretion of the Board.

(2) The Board may use the status conference to discuss any of the following:

- (i) Simplification of the issues.
- (ii) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement.
- (iii) Stipulations and admissions of fact or as to the content and authenticity of documents.
- (iv) Whether the parties can agree to submission of the case on a stipulated record.
- (v) Whether a party may waive appearance at an oral hearing and submit only documentary evidence (the admissibility of which is subject to objection from other parties) and written argument.
- (vi) Limitation of the number of witnesses.
- (vii) Scheduling dates for the exchange of witness lists and of proposed exhibits.
- (viii) Discovery as permitted under this section.
- (ix) The time and place for the hearing.
- (x) Potential settlement of some or all of the issues.
- (xi) Other matters that the Board deems necessary and appropriate. The Board may issue any orders at the conference found necessary and appropriate to narrow the issues further and expedite further proceedings in the appeal.

(3) After the status conference, the Board may—

(i) Issue in writing a report and order specifying what transpired and formalizing any orders issued at the conference; and

(ii) Require the parties to submit (jointly or otherwise) a proposed report and order, in order to facilitate issuance of a final report and order.

(d) *Further status conferences.* Upon a party's request, or on its own motion, the Board may conduct further status conferences where it finds the proceedings necessary and appropriate.

(e) *Discovery*—(1) *General rules.* (i) Discovery is limited in Board proceedings.

(ii) The Board may permit discovery of a matter that is relevant to the specific subject matter of the Board hearing, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate.

(iii) Any discovery initiated by a party must comply with all requirements and limitations of this section, and with any further requirements or limitations ordered by the Board.

(iv) The applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance for any discovery that is permitted under this section or by Board order.

(2) *Limitations on discovery.* Any discovery before the Board is limited as follows:

(i) A party may request of another party, or of a nonparty other than CMS, the Secretary or any Federal agency, the reasonable production of documents for inspection and copying.

(ii) A party may also request another party to respond to a reasonable number of written interrogatories.

(iii)(A) A party may not take the deposition, upon oral or written examination, of another party or a nonparty, unless the proposed deponent agrees to the deposition or the Board finds that the proposed deposition is necessary and appropriate under the criteria set forth in Federal Rules of Civil Procedure 26 and 32(a)(3) in order to secure the deponent's testimony for a Board hearing.

(B) The regulations at 45 CFR Part 2 (Testimony by employees and production of documents in proceedings where the United States is not a party) apply as to whether an employee or officer of CMS or HHS will appear for a deposition.

(iv) A party may not request admissions or take any other form of discovery not authorized under this section.

(3) *Time limits.* (i) A party's discovery request is timely if the date the request is served on another party or nonparty, as applicable, is no later than 120 days before the initially scheduled starting date of the Board hearing, unless the Board extends the time for the request.

(ii)(A) *Depositions.* (1) In the absence of an order or instruction by the Board setting a schedule for the holding of a deposition, a party desiring to take a deposition must give reasonable notice in writing to the deponent of a scheduled deposition.

(2) A deposition may not be held any later than 45 days before the initially scheduled starting of the Board hearing, unless the Board orders otherwise.

(B) *Responses.* (1) In the absence of a Board order or general instructions of the Board setting a schedule for responses, responses to interrogatories and requests for production of documents are due according to the schedule agreed upon by the party serving discovery and the party to which the discovery is directed, or within the time allotted by the Federal Rules of Civil Procedure.

(2) Responses by a party to interrogatories, and responses by a party or nonparty to requests for production of documents, must be served no later than 45 days before the initially scheduled starting date of the Board hearing, unless the Board orders otherwise.

(iii) Before ruling on a request to extend the time for requesting discovery or for conducting or responding to discovery, the Board must give the other parties to the appeal, and any nonparty subject to a discovery request, a reasonable period to respond to the extension request.

(iv) The Board has the discretion to extend the time in which to request

discovery or conduct or respond to discovery.

(v) If the Board grants the extension request, it sets a new discovery deadline and has the discretion to reschedule the hearing date.

(4) *Rights of nonparties.* If a discovery request is made of a nonparty to the Board appeal, the nonparty has the rights any party has in responding to a discovery request. The rights of the nonparty include, but are not limited to, the right to select and use any attorney or other representative, and to submit discovery responses, objections, or motions to the Board.

(5) *Motions to compel or for protective order.* (i) Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty.

(ii) A party may submit to the Board a motion to compel discovery that is permitted under this section or any Board order, and a party or nonparty may submit a motion for a protective order regarding any discovery request to the Board.

(iii) Any motion to compel or for protective order must include a self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute.

(iv) A self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute must be included with any response to a motion to compel or for protective order.

(v) The Board must decide any motion in accordance with this section and any prior discovery ruling.

(vi)(A) The Board must issue and send to each party and any affected nonparty a discovery ruling that grants or denies, in whole or in part, the motion to compel or the motion for a protective order, if applicable.

(B) The discovery ruling must—

(1) Specifically identify any part of the disputed discovery request upheld and any part rejected, and

(2) Impose any limits on discovery the Board finds necessary and appropriate.

(vii) Nothing in this section authorizes the Board to compel any action from the Secretary or CMS.

(6) *Reviewability of discovery and disclosure rulings*—(i) *General rule.* A Board discovery ruling, or a Board disclosure ruling, such as one issued at a hearing, is not subject to immediate review by the Administrator (as described in § 405.1875(a)(3) of this subpart). The ruling may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final or deemed to be final, by the Administrator, under § 405.1875(a)(2) of this subpart, or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this subpart, as applicable.

(ii) *Exception.* To the extent a ruling authorizes discovery or disclosure of a matter for which an objection based on privilege, or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before the Board, that portion of the discovery or disclosure ruling may be reviewed immediately by the Administrator in accordance with § 405.1875(a)(3)(i) of this subpart. Upon notice to the Board that a party or nonparty, as applicable, intends to seek Administrator review of the ruling,—

(A)(1) The Board must stay all proceedings affected by the ruling.

(2) The Board determines the length of the stay under the circumstances of a given case, but in no event may the length of the stay be less than 15 days after the day on which the Board received notice of the party or nonparty's intent to seek Administrator review.

(B) If the Administrator—

(1) Grants a request for review, or takes own motion review, of a ruling, the ruling is stayed until the time the Administrator issues a written decision that affirms, reverses, modifies, or remands the Board's ruling.

(2) Does not grant a request or take own motion review within the time allotted for the stay, the stay is lifted and the ruling is not subject to immediate review.

[73 FR 30257, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1855 Evidence at Board hearing.

Evidence may be received at the Board hearing even though inadmis-

sible under the rules of evidence applicable to court procedure. The Board shall give the parties opportunity for submission and consideration of facts and arguments and during the course of the hearing should, in ruling upon admissibility of evidence, exclude irrelevant, immaterial, or unduly repetitious evidence. The Board shall render a final ruling on the admissibility of evidence.

§ 405.1857 Subpoenas.

(a) *Time limits.* (1) The Board may issue a subpoena—

(i) To a party to a Board appeal or to a nonparty other than CMS or the Secretary or any Federal agency, requiring the attendance and testimony of witnesses or the production of documents for inspection and copying, provided the Board makes a preliminary finding of its jurisdiction over the matters at issue in accordance with § 405.1840(a) of this subpart.

(ii) At the request of a party for purposes of discovery (as described in § 405.1853 of this subpart) or an oral hearing (as described in § 405.1845 of this subpart); and

(iii) On its own motion solely for purposes of a hearing.

(2) The date of receipt by the Board of a party's subpoena request may not be any later than for subpoenas requested for purposes of—

(i) Discovery, 120 days before the initially scheduled starting date of the Board hearing; and

(ii) An oral hearing, 45 days before the scheduled starting date of the Board hearing.

(3) Subject to paragraph (4) of this section, the Board may not issue a subpoena any later than for purposes of—

(i) Discovery, 90 days before the initially scheduled starting date of the Board hearing; and

(ii) An oral hearing, whether issued at a party's request or on the Board's own motion, 30 days before the scheduled starting date of the Board hearing.

(4) The Board may extend the deadlines specified in paragraphs (a)(2) and (a)(3) of this section provided the Board gives each party to the appeal and any nonparty subject to the subpoena request or subpoena a reasonable period

of time to comment on any proposed extension. If the Board extends a deadline, it retains the discretion to reschedule the hearing date.

(b) *Criteria*—(1) *Discovery subpoenas*. The Board may issue a subpoena for purposes of discovery if all of the following are applicable:

(i) The subpoena was requested in accordance with the requirements of paragraph (c)(1) of this section.

(ii) The party's discovery request complies with the applicable provisions of § 405.1853(e) of this part.

(iii) A subpoena is necessary and appropriate to compel a response to the discovery request.

(2) *Hearing subpoenas*. The Board may issue a subpoena for purposes of an oral hearing if—

(i) The party's subpoena request meets the requirements of paragraph (c)(1) of this section;

(ii) A subpoena is necessary and appropriate to compel the attendance and testimony of witnesses or the production of documents for inspection or copying, provided the testimony or documents are relevant and material to a matter at issue in the appeal but not unduly repetitious (as described in § 405.1855 of this subpart); and

(iii) The subpoena does not compel the disclosure of matter that is privileged or otherwise protected from disclosure for reasons such as case preparation, confidentiality, or undue burden.

(iv) The subpoena does not impose undue burden or expense on the party or nonparty subject to the subpoena, and is not otherwise unreasonable or inappropriate.

(3) *Guiding principles*. In determining whether to issue, quash, or modify a subpoena under this section, the Board uses the applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence for guidance.

(c) *Procedures*— (1) *Subpoena requests*. The requesting party must send any subpoena request submitted to the Board promptly to the party or nonparty subject to the subpoena, and to any other party to the Board appeal. If the subpoena request is being sent to a nonparty subject to the subpoena,

then the subpoena request must be sent by certified mail. The request must—

(i) Identify with particularity any witnesses (and their addresses, if known) or any documents (and their location, if known) sought by the subpoena, and the means, time, or location for securing any witness testimony or documents;

(ii) Describe specifically, in the case of a hearing subpoena, the facts any witnesses, documents, or tangible materials are expected to establish, and why those facts cannot be established without a subpoena; and

(iii) Explain why a subpoena is appropriate under the criteria prescribed in paragraph (b) of this section.

(2) *Contents of subpoenas*. A subpoena issued by the Board, whether on its own motion or at the request of a party, must be in writing and either sent promptly by the Board to the party or nonparty subject to the subpoena by certified mail or overnight delivery (and to any other party and affected nonparty to the appeal by regular mail), or hand-delivered. Each subpoena must—

(i) Be issued in the name of the Board, and include the case number and name of the appeal;

(ii) Provide notice that—

(A) The subpoena is issued in accordance with section 1878(e) of the Act and § 405.1857 of this subpart; and

(B) CMS must pay the fees and the mileage of any witnesses, as provided in section 205(d) of the Act.

(iii) If applicable, require named witnesses to attend a particular proceeding at a certain time and location and to testify on specific subjects; and

(iv) If applicable, require the production of specific documents for inspection or copying at a certain time and location.

(3) *Rights of nonparties*. If a nonparty to the Board appeal is subject to the subpoena or subpoena request, the nonparty has the rights any party has in responding to a subpoena or subpoena request. The rights of the nonparty include, but are not limited to, the right to select and use any attorney or other representative, and to submit responses, objections, motions, or any other pertinent materials to the

Board regarding the subpoena or subpoena request.

(4) *Board action on subpoena requests and motions.* After issuing a subpoena or receiving a subpoena request, the Board must do the following:

(i) Give the party or nonparty subject to the subpoena or subpoena request a reasonable period of time for the submission of any responses, objections, or motions.

(ii) Consider the subpoena or subpoena request, and any responses, objections, or motions related thereto, under the criteria specified in paragraph (b) of this section.

(iii)(A) Issue in writing and send promptly to each party and any affected nonparty an order granting or denying any motion to quash or modify a subpoena, or granting or denying any subpoena request in whole or in part; and

(B) Issue, if applicable, an original or modified subpoena in accordance with paragraph (c)(2) of this section.

(d) *Reviewability*—(1) *General rules.* (i) If the Board issues, quashes, or modifies, or refuses to issue, quash, or modify, a subpoena under paragraphs (c)(2) or (c)(4) of this section, the Board's action is not subject to immediate review by the Administrator (as described in § 405.1875(a)(3) of this subpart).

(ii) Any Board action on a subpoena may be reviewed solely during the course of Administrator review of one of the Board decisions specified in § 405.1875(a)(2) of this subpart, or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this subpart, as applicable.

(2) *Exception.* (i) To the extent a subpoena compels disclosure of a matter for which an objection based on privilege, or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before the Board, the Administrator may review immediately that portion of the subpoena in accordance with § 405.1875(a)(3)(ii) of this subpart.

(ii) Upon notice to the Board that a party or nonparty, as applicable, intends to seek Administrator review of the subpoena, the Board must stay all proceedings affected by the subpoena.

(iii) The Board determines the length of the stay under the circumstances of

a given case, but in no event may the stay be less than 15 days after the day on which the Board received notice of the party or nonparty's intent to seek Administrator review.

(iv) If the Administrator grants a request for review, or takes own motion review, of the subpoena, the subpoena or portion of the subpoena, as applicable, is stayed until such time as the Administrator issues a written decision that affirms, reverses, modifies, or remands the Board's action on the subpoena.

(v) If the Administrator does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the Board's action is not immediately reviewable.

(e) *Enforcement.* (i) If the Board determines, whether on its own motion or at the request of a party, that a party or nonparty subject to a subpoena issued under this section has refused to comply with the subpoena, the Board may request the Administrator to seek enforcement of the subpoena in accordance with section 205(e) of the Act.

(ii) Any enforcement request by the Board must consist of a written notice to the Administrator describing in detail the Board's findings of noncompliance and its specific request for enforcement, and providing a copy of the subpoena and evidence of its receipt by certified mail by the party or nonparty subject to the subpoena.

(iii) The Board must promptly mail a copy of the notice and related documents to the party or nonparty subject to the subpoena, and to any other party and affected nonparty to the appeal.

[73 FR 30258, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1859 Witnesses.

Witnesses at the hearing shall testify under oath or affirmation, unless excused by the Board for cause. The Board may examine the witnesses and shall allow the parties or their representatives to do so. Parties to the proceeding may also cross-examine witnesses.

§ 405.1861 Oral argument and written allegations.

The parties, upon their request, shall be allowed a reasonable time for the presentation of oral argument or for the filing of briefs or other written statements of allegations as to facts or law. Copies of any brief or other written statement shall be filed in sufficient number that they may be made available to all parties and to the Centers for Medicare & Medicaid Services.

§ 405.1863 Administrative policy at issue.

Where a party to the Board hearing puts into issue an administrative policy which is interpretative of the law or regulations, the Board will promptly notify to the Centers for Medicare & Medicaid Services.

§ 405.1865 Record of administrative proceedings.

(a)(1) The Board and, if applicable, the Administrator must maintain a complete record of all proceedings in each appeal.

(2) For proceedings before the Board, the administrative record consists of all evidence, documents and any other tangible materials submitted by the parties to the appeal and by any nonparty (as described in §§ 405.1853(e)(4) and 405.1857(c)(3) of this subpart), along with all Board correspondence, rulings, subpoenas, orders, and decisions.

(3) The term “record” is intended to encompass both the unappended record and any appendix to the record (as described in § 405.1865(b) of this subpart).

(4) The record includes a complete transcription of the proceedings at any oral hearing before the Board.

(5) A copy of any transcription must be made available to any party upon written request.

(b) Any evidence ruled inadmissible by the Board (as described in § 405.1855 of this subpart) and any other submitted matter that the Board declines to consider (whether as untimely or otherwise) must be, to the extent practicable, clearly identified and segregated in an appendix to the record for purposes of any further review (as described in §§ 405.1875 and 405.1877 of this subpart).

(c) To the extent applicable, the administrative record also includes all documents (including written submissions) and any other tangible materials submitted to the Administrator by the parties to the appeal or by any nonparty (as described in §§ 405.1853(e)(4) and 405.1857(c)(3) of this subpart), in addition to all correspondence from the Administrator or the Office of the Attorney Advisor, and all rulings, orders, and decisions by the Administrator. The provisions of paragraph (b) of this section also pertain to any proceedings before the Administrator, to the extent the Administrator finds evidence inadmissible or declines to consider a specific matter (whether as untimely or otherwise).

[73 FR 30260, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1867 Scope of Board’s legal authority.

In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

[48 FR 22925, May 23, 1983, as amended at 73 FR 30260, May 23, 2008; 73 FR 49356, Aug. 21, 2008]

§ 405.1868 Board actions in response to failure to follow Board rules.

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board’s powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

(b) 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.

(c) If a contractor fails to meet a filing deadline or other requirement established by the Board, the Board may—

- (1) Take other actions that it considers appropriate, such as—

- (i) Issuing a decision based on the written record submitted to that point; or

- (ii) Issuing a written notice to CMS describing the contractor's actions and requesting that CMS take appropriate action, such as review of the contractor's compliance with the contractual requirements of §§ 421.120, 421.122, and 421.124 of this chapter; and

- (2) Not use its authority to take an action such as, a sanction, reversing or modifying the contractor's or Secretary's determination for the cost reporting period under appeal, or ruling against the contractor on a disputed issue of law or fact in the appeal.

(d)(1) If the Board dismisses the appeal with prejudice under this section, it must issue a dismissal decision dismissing the appeal. The decision by the Board must be in writing and include an explanation of the reason for the dismissal. A copy of the Board's dismissal decision must be sent promptly to each party to the appeal (as described in § 405.1843 of this subpart).

(2) A dismissal decision by the Board is final and binding on the parties unless the decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(ii), and § 405.1875(e) or § 405.1875(f) of this part, no later than 60 days after the date of receipt by the provider of the Board's decision.

(i) The Board decision is inoperative during the 60-day period for review by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands the decision within the period.

(ii) The Board may reopen and revise a final Board decision in accordance with §§ 405.1885 through 405.1889 of this subpart.

(e)(1) Any action taken by the Board under this section other than dismissal of the appeal is not subject to immediate Administrator review (as described in § 405.1875(a)(3) of this subpart) or judicial review (as described in § 405.1877(a)(3) of this subpart).

(2) A Board action other than dismissal of the appeal may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2) of this subpart, or of judicial review of a final agency decision as described in § 405.1877(a) of this subpart, as applicable.

(f) *Ex parte* communications with Board staff concerning procedural matters are not prohibited.

(g) Upon receipt of a credible allegation that a party's representative has divulged to that party, or to the Board, information that was obtained during the course of the representative's relationship (such as legal counsel or employee) with an opposing party and that was intended by that party to be kept confidential, the Board—

- (1) Investigates the allegation; and

- (2) May take remedial action when it determines that it is appropriate to do so, against the party or the representative (such as prohibiting the representative from appearing before it, excluding such information from the record, or if the overall fairness of the hearing has been compromised, dismissing the case).

[73 FR 30260, May 23, 2008; 73 FR 49356, Aug. 21, 2008; 85 FR 59019, Sept. 18, 2020]

§ 405.1869 Scope of Board's authority in a hearing decision.

(a) If the Board has jurisdiction to conduct a hearing on a specific matter at issue under section 1878(a) or (b) of the Act and § 405.1840 of this subpart, and the legal authority to fully resolve the matter in a hearing decision (as described in §§ 405.1842(f), 405.1867, and 405.1871 of this subpart), section 1878 of

the Act, and paragraph (a) of this section give the Board the power to affirm, modify, or reverse the contractor's findings on each specific matter at issue in the contractor determination for the cost reporting period under appeal, and to make additional revisions on specific matters regardless of whether the contractor considered the matters in issuing the contractor determination. The Board's power to make additional revisions in a hearing decision does not authorize the Board to consider or decide a specific matter at issue for which it lacks jurisdiction (as described in § 405.1840(b) of this subpart) or which was not timely raised in the provider's hearing request. The Board's power under section 1878(d) of the Act and paragraph (a) of this section to make additional revisions is limited to those revisions necessary to resolve fully a specific matter at issue if—

(1) The Board has jurisdiction to grant a hearing on the specific matter at issue under section 1878(a) or (b) of the Act and § 405.1840 of this subpart; and

(2) The specific matter at issue was timely raised in an initial request for a Board hearing filed in accordance with § 405.1835 or § 405.1837 of this subpart, as applicable, or in a timely request to add issues to a single provider appeal submitted in accordance with § 405.1835(c) of this subpart.

(b)(1) If the Board has jurisdiction to conduct a hearing on a specific matter at issue solely under §§ 405.1840 and 405.1835 or § 405.1837 of this subpart, as applicable, and the legal authority to fully resolve the matter in a hearing decision (as described in §§ 405.1842(f), 405.1867, and 405.1871 of this subpart), the Board is authorized to do the following:

(i) Affirm, modify, or reverse the contractor's or Secretary's findings on each specific matter at issue in the contractor or Secretary determination under appeal.

(ii) Make additional revisions on each specific matter at issue regardless of whether the contractor considered these revisions in issuing the contractor determination under appeal, provided the Board does not consider or decide a specific matter for which it

lacks jurisdiction (as described in § 405.1840(b) of this subpart) or that was not timely raised in the provider's hearing request.

(2) The Board's authority under this section to make the additional revisions is limited to those revisions necessary to resolve a specific matter at issue.

[73 FR 30261, May 23, 2008]

§ 405.1871 Board hearing decision.

(a)(1) If the Board finds jurisdiction over a specific matter at issue and conducts a hearing on the matter (as described in §§ 405.1840(a) and 405.1845(e) of this subpart), the Board must issue a hearing decision deciding the merits of the specific matter at issue.

(2) A Board hearing decision must be in writing and based on the admissible evidence from the Board hearing and other admissible evidence and written argument or comments as may be included in the record and accepted by the Board (as described in §§ 405.1845(g) and 405.1865 of this subpart).

(3) The decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and whether the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue.

(4) The decision must include appropriate citations to the record evidence and to the applicable law, regulations, CMS Rulings, and other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS. Where the Board's decision reverses or modifies a contractor determination on an issue for which the policy expressed in an interpretive rule (other than a regulation or a CMS Ruling), general statement of policy or rule of agency organization, procedure or practice established by CMS would be dispositive of that issue (if followed by the Board), the Board decision must explain how it gave great weight to such interpretive rule or other such instruction but did not uphold the contractor's determination on the issue.

(5) A copy of the decision must be sent promptly to each party to the appeal.

(b)(1) A Board hearing decision issued in accordance with paragraph (a) of this section is final and binding on the parties to the Board appeal unless the hearing decision is reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(a)(2)(i), 405.1875(e), and 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.

(2) A Board hearing decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision within the period.

(3) A Board hearing decision that is final under paragraph (b)(1) of this section is subject to the provisions of § 405.1803(d) of this subpart, unless the decision is the subject of judicial review (as described in § 405.1877 of this subpart).

(4) A final Board decision under paragraph (a) and (b) of this section may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart.

(5) When the contractor's denial of the relief that the provider seeks before the Board is based on procedural grounds (for example, the alleged failure of the provider to satisfy a time limit) or is based on the alleged failure to supply adequate documentation to support the provider's claim, and the Board rules that the basis of the contractor's denial is invalid, the Board remands to the contractor for the contractor to make a determination on the merits of the provider's claim.

[73 FR 30261, May 23, 2008, as amended at 85 FR 59019, Sept. 18, 2020]

§ 405.1873 Board review of compliance with the reimbursement requirement of an appropriate cost report claim.

(a) *General.* In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). If

the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.

(b) *Summary of procedures—(1) Preliminary steps.* The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter. In reaching such specific factual findings and legal conclusions, the Board must follow the procedures set forth in § 413.24(j)(3) of this chapter for determining whether the provider's cost report included an appropriate claim for the specific item under appeal. The Board must promptly give a copy of such written specific factual findings and legal conclusions to each party to the appeal, and such factual findings and legal conclusions must be included in the record of administrative proceedings for the appeal (as prescribed in § 405.1865).

(2) *Limits on Board actions.* The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction over a specific item or take any other of the actions specified in paragraph (c) of this section. Upon giving the parties to the appeal the Board's written specific factual findings and legal conclusions (pursuant to paragraph (b)(1) of this section) on the question of whether the provider's cost report included an appropriate cost report claim for the specific item under appeal, the Board must proceed to issue one of the four types of overall

decisions specified in paragraphs (d) and (e) of this section with respect to the specific item. If the Board issues either of two types of overall Board decisions (as specified in paragraph (d) of this section) regarding the specific item under appeal, the Board's written specific factual findings and legal conclusions (pursuant to paragraph (b)(1) of this section) must be included in such overall Board decision regarding the specific item, along with the other matters that are required by the regulations for the pertinent type of overall Board decision. However, if the Board issues either of two other types of overall Board decisions (as specified in paragraph (e) of this section) regarding the specific item under appeal, the Board's written specific factual findings and legal conclusions (pursuant to paragraph (b)(1) of this section) must not be included in the overall Board decision regarding the specific item. The Board may permit reimbursement for the specific item under appeal, as part of one of the two types of overall Board decisions that are specified in paragraph (d) of this section, but such reimbursement may be permitted only to the extent authorized by paragraph (f) of this section.

(c) *Prohibition of certain types of decisions, orders, and other actions.* (1) If the Board determines, in its findings of fact and conclusions of law (as prescribed by paragraph (b)(1) of this section), that the provider's cost report did not include an appropriate claim for the specific item under appeal, the Board may not—

(i) Deny jurisdiction over the specific item under appeal, based on (in whole or in part) the Board's factual findings and legal conclusions (reached under paragraph (b)(1) of this section);

(ii) Decline to exercise jurisdiction over the specific item under appeal, based on (in whole or in part) the Board's factual findings and legal conclusions (reached under paragraph (b)(1) of this section); or

(iii) Take any of the actions set forth in § 405.1868(b), (c), or (d), impose any sanction, or take any other action against the interests of any party to the appeal, except as provided in paragraph (f) of this section, based on (in whole or in part) the Board's factual

findings and legal conclusions (reached under paragraph (b)(1) of this section).

(2) Regardless of whether the Board determines, in its findings of fact and conclusions of law (as prescribed by paragraph (b)(1) of this section), that the provider's cost report did or did not include an appropriate claim for the specific item under appeal, the Board may not—

(i) Deny jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item. *Exception:* If the provider's appeal of the specific item is based on a reopening of such item (pursuant to § 405.1885) where the specific item is not revised, adjusted, corrected, or otherwise changed in a revised final contractor or Secretary determination, the Board must deny jurisdiction over the specific item under appeal (as prescribed in §§ 405.1887(d) and 405.1889(b));

(ii) Decline to exercise jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item; or

(iii) Take any of the actions set forth in § 405.1868(b), (c), or (d), impose any sanction, or take any other action against the interests of any party to the appeal, except as provided in paragraph (f) of this section, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item.

(d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1)*

of this section—(1) *Board hearing decision.* If the Board issues a hearing decision regarding the specific item under appeal (pursuant to §405.1871), any specific findings of fact and conclusions of law by the Board (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, must be included in such hearing decision along with the other matters prescribed by §405.1871(a). The Board's factual findings and legal conclusions (reached under paragraph (b)(1) of this section), about whether there was an appropriate cost report claim for the specific item under appeal, are subject to the provisions of §405.1871(b) just as those provisions apply to the other parts of the Board's hearing decision. If the Board determines that the provider's cost report—

(i) Included an appropriate claim for the specific item under appeal (as prescribed in §413.24(j) of this chapter), the Board's hearing decision must also address whether the other substantive reimbursement requirements for the specific item are also satisfied; or

(ii) Did not include an appropriate claim for the specific item under appeal, the Board has discretion whether or not to address in the Board's hearing decision whether the other substantive reimbursement requirements for the specific item are also satisfied.

(2) *Board expedited judicial review (EJR) decision, where EJR is granted.* If the Board issues an EJR decision where EJR is granted regarding a legal question that is relevant to the specific item under appeal (in accordance with §405.1842(f)(1)), the Board's specific findings of fact and conclusions of law (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, must be included in such EJR decision along with the other matters prescribed by §405.1842(f)(1). The Board's factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section) about whether there was an appropriate cost report claim for the specific item under appeal are subject to the provisions of §405.1842(g)(1), (g)(2), (h)(1), and (h)(3) in the same

manner as those provisions apply to the other parts of the Board's EJR decision.

(e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section—(1) Board jurisdictional dismissal decision.* If the Board issues a jurisdictional dismissal decision regarding the specific item under appeal (pursuant to §405.1840(c)), the Board's specific findings of fact and conclusions of law (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, must not be included in such jurisdictional dismissal decision.

(2) *Board expedited judicial review (EJR) decision, where EJR is denied.* If the Board issues an EJR decision where EJR is denied regarding a legal question that is relevant to the specific item under appeal (in accordance with §405.1842(f)(2)), the Board's specific findings of fact and conclusions of law (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the same item, must not be included in such EJR decision. If the Board conducts further proceedings and issues another decision (as specified in §405.1842(h)(2)(i)), the Board's specific findings of fact and conclusions of law (in accordance with paragraph (b)(1) of this section)—

(i) Must be included in any further hearing decision or EJR decision where EJR is granted regarding the specific item under appeal (as specified in paragraph (d) of this section); but

(ii) Must not be included in any further jurisdictional dismissal decision or EJR decision where EJR is denied regarding the specific item under appeal (as prescribed in paragraph (e) of this section).

(f) *Effects of the Board's factual findings and legal conclusions under paragraph (b)(1) of this section in two types of final decisions—(1) When part of a final hearing decision.* If the Board determines, or the Administrator of CMS determines (pursuant to §405.1875(a)(2)(v)), as applicable, in a final and binding hearing decision (in

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accordance with § 405.1871(b) and paragraphs (b)(1) and (d)(1) of this section), that the provider's cost report—

(i) Included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter), the specific item is reimbursable in accordance with Medicare policy, but only if the Board further determines in such final hearing decision that all the other substantive reimbursement requirements for the specific item are also satisfied; or

(ii) Did not include an appropriate cost report claim for the specific item under appeal, the specific item is not reimbursable, regardless of whether the Board further determines in such final hearing decision that the other substantive reimbursement requirements for the specific item are or are not satisfied.

(2) *When part of a final EJR decision that grants EJR.* If the Board determines or the Administrator of CMS determines (pursuant to § 405.1875(a)(2)(v)), as applicable, in a final and binding EJR decision that grants EJR regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(g)(1) and paragraphs (b)(1) and (d)(2) of this section), that the provider's cost report—

(i) Included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter), the specific item is reimbursable in accordance with Medicare policy, but only to the extent permitted by the final decision of a Federal court pursuant to the EJR provisions of section 1878(f)(1) of the Act (refer also to §§ 405.1842 and 405.1877); or

(ii) Did not include an appropriate claim for the specific item under appeal, the specific item is not reimbursable, unless—

(A) The specific factual findings and legal conclusions (in accordance with paragraph (b)(1) of this section) of the Board or the Administrator, as applicable, on the question of whether the provider's cost report included an appropriate claim for the specific item under appeal, are reversed or modified by the final decision of a Federal court (in accordance with section 1878(f)(1) of the Act and § 405.1877); and

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(B) Only to the extent otherwise permitted by the final decision of a Federal court pursuant to the EJR provisions of section 1878(f)(1) of the Act (refer also to §§ 405.1842 and 405.1877) and by Medicare policy.

[80 FR 70600, Nov. 13, 2015]

§ 405.1875 Administrator review.

(a) *Basic rule: Time limit for rendering Administrator decisions, Board decisions, and action subject to immediate review.* The Administrator, at his or her discretion, may immediately review any decision of the Board specified in paragraph (a)(2) of this section. Nonfinal decisions or actions by the Board are not immediately reviewable, except as provided in paragraph (a)(3) of this section. The Administrator may exercise this discretionary review authority on his or her own motion, or in response to a request from: a party to the Board appeal; CMS; or, in the case of a matter specified in paragraph (a)(3)(i) or (a)(3)(ii) of this section, another affected nonparty to a Board appeal. All requests for Administrator review and any other submissions to the Administrator under paragraph (c) of this section must be sent to the Office of the Attorney Advisor. The Office of the Attorney Advisor must examine each Board decision specified in paragraph (a)(2) of this section, and each matter described in § 405.1845(h)(3), § 405.1853(e)(6)(ii), or § 405.1857(d)(2) of this subpart, of which it becomes aware, together with any review requests or any other submission made in accordance with the provisions of this section, in order to assist the Administrator's exercise of this discretionary review authority. The Board is required to send to the Office of the Attorney Advisor a copy of each decision specified in paragraphs (a)(2)(i), (ii), and (iii) of this section upon issuance of the decision.

(1) The date of rendering any decision after the review by the Administrator must be no later than 60 days after the date of receipt by the provider of a reviewable Board decision or action. For purposes of this section, the date of rendering is the date the Administrator signs the decision, and not the date the decision is mailed or otherwise transmitted to the parties.

(2) The Administrator may immediately review:

(i) A Board hearing decision (as described in § 405.1871 of this subpart).

(ii) A Board dismissal decision (as described in §§ 405.1836(e)(1) and (e)(2), 405.1840(c)(2) and (c)(3), 405.1868(d)(1) and (d)(2) of this subpart).

(iii) A Board EJR decision, but only the question of whether there is Board jurisdiction over a specific matter at issue in the decision; the Administrator may not review the Board's determination in a decision of its authority to decide a legal question relevant to the matter at issue (as described in § 405.1842(h) of this subpart).

(iv) Any other Board decision or action deemed to be final by the Administrator.

(v) If the Administrator reviews a Board hearing decision regarding a specific item, or for a Board EJR decision the question of whether there is Board jurisdiction over a specific item, the Administrator's review of such a hearing decision or EJR decision, as applicable, will include, and any decision issued by the Administrator (under paragraph (e) of this section) will address, the Board's specific findings of fact and conclusions of law in such hearing decision or EJR decision (as prescribed in § 405.1873(b)(1) and (d)) on the question of whether the provider's cost report included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter).

(3) Any decision or action by the Board not specified in paragraph (a)(2)(i) through (a)(2)(iii) of this section, or not deemed to be final by the Administrator under paragraph (a)(2)(iv) of this section, is nonfinal and not subject to Administrator review until the Board issues one of the decisions specified in paragraph (a)(2) of this section, except the Administrator may review immediately the following matters:

(i) A Board ruling authorizing discovery or disclosure of a matter for which an objection was made based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden (as described in § 405.1853(e)(6)(ii) of this subpart).

(ii) A Board subpoena compelling disclosure of a matter for which an objection was made based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden (as described in § 405.1857(d)(2) of this subpart).

(b) *Illustrative list of criteria for deciding whether to review.* In deciding whether to review a Board decision or other matter specified in paragraphs (a)(2) and (a)(3) of this section, either on his or her own motion or in response to a request for review, the Administrator considers criteria such as whether it appears that—

(1) The Board made an erroneous interpretation of law, regulation, CMS Ruling, or other interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice established by CMS.

(2) A Board hearing decision meets the requirements of § 405.1871(a) of this subpart.

(3) The Board erred in refusing to admit certain evidence or in not considering other submitted matter (as described in §§ 405.1855 and 405.1865(b) of this subpart), or in admitting certain evidence.

(4) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to the issuance of a CMS Ruling or other directive needed to clarify a statutory or regulatory provision.

(5) The Board has incorrectly found, assumed, or denied jurisdiction over a specific matter at issue or extended its authority in a manner not provided for by statute, regulation, CMS Ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

(6) The decision or other action of the Board requires clarification, amplification, or an alternative legal basis.

(7) A remand to the Board may be necessary or appropriate under the criteria prescribed in paragraph (f) of this section.

(c) *Procedures—(1) Review requests.* (i)(A) A party to a Board appeal or CMS may request Administrator review of a Board decision specified in paragraph (a)(2) of this section or a

matter described in paragraph (a)(3) of this section.

(B) A nonparty other than CMS may request Administrator review solely of a matter described in paragraph (a)(3)(i) or (a)(3)(ii) of this section.

(ii) The date of receipt by the Office of Attorney Advisor of any review request must be no later than 15 days after the date the party making the request received the Board's decision or other reviewable action.

(iii) A request for review (or a response to a request) must be submitted in writing, identify the specific issues for which review is requested, and explain why review is or is not appropriate, under the criteria specified in paragraph (b) of this section or for some other reason.

(iv) A copy of any review request (or response to a request) must be sent promptly to each party to the appeal, the Office of the Attorney Advisor, and, as applicable, CMS, and any other affected nonparty.

(2) *Exception to time for requesting review.* If a party, or nonparty, as applicable, seeks immediate review of a matter described in § 405.1875(a)(3)(i) or (a)(3)(ii) of this subpart, the request for review must be made as soon as practicable, but in no event later than 5 business days after the day the party or nonparty seeking review received notice of the ruling or subpoena. The request must state the reason(s) why the ruling was in error and the potential harm that may be caused if immediate review is not granted.

(3) *Notice of review.* (i) When the Administrator decides to review a Board decision or other matter specified in paragraphs (a)(2) or (a)(3) of this section, respectively, whether on his or her own motion or upon request, the Administrator must send a written notice to the parties, CMS, and any other affected nonparty stating that the Board's decision is under review, and indicating the specific issues that are being considered.

(ii) The Administrator may decline to review a Board decision or other matter, or any issue in a decision or matter, even if a request for review is submitted in accordance with paragraph (c)(1) or (c)(2) of this section.

(4) *Written submissions on review.* If the Administrator accepts review of the Board's decision or other reviewable action, a party, CMS, or, another affected nonparty that requested review solely of a matter described in paragraph (a)(3)(i) or (a)(3)(ii) of this section, may tender written submissions regarding the review.

(i) The date of receipt by the Office of the Attorney Advisor of any material must be no later than 15 days after the date the party, CMS or other affected nonparty submitting comments received the Administrator's notice under paragraph (c)(3) of this section, taking review of the Board decision or other reviewable matter.

(ii) Any submission must be limited to the issues accepted for Administrator review (as identified in the notice) and be confined to the record of Board proceedings (as described in § 405.1865 of this subpart). The submission may include—

(A) Argument and analysis supporting or taking exception to the Board's decision or other reviewable action;

(B) Supporting reasons, including legal citations and excerpts of record evidence, for any argument and analysis submitted under paragraph (c)(4)(ii)(A) of this section;

(C) Proposed findings of fact and conclusions of law;

(D) Rebuttal to any written submission filed previously with the Administrator in accordance with paragraph (c)(4) of this section; or

(E) A request, with supporting reasons, that the decision or other reviewable action be remanded to the Board.

(d) *Ex parte communications prohibited.* The Administrator does not consider any communication that does not meet the following requirements or is not submitted within the required time limits. All communications from any party, CMS, or other affected nonparty, concerning a Board decision (or other reviewable action) that is being reviewed or may be reviewed by the Administrator must—

(1) Be in writing.

(2) Contain a certification that copies were served on all other parties, CMS, and any other affected nonparty, as applicable.

(3) Include, but are not limited to—

(i) Requests for review and responses to requests for review submitted under paragraph (c)(1) or (c)(2) of this section; and

(ii) Written submissions regarding review submitted under paragraph (c)(4) of this section.

(e) *Administrator's decision.* (1) Upon completion of any review, the Administrator may render a written decision that—

(i) For purposes of review of a Board decision specified in paragraph (a)(2) of this section, affirms, reverses, or modifies the Board's decision, or vacates that decision and remands the case to the Board for further proceedings in accordance with paragraph (f)(1)(i) of this section; or

(ii) For purposes of review of a matter described in paragraph (a)(3) of this section, affirms, reverses, modifies, or remands the Board's discovery or disclosure ruling, or subpoena, as applicable, and remands the case to the Board for further proceedings in accordance with paragraph (f)(1)(ii) of this section.

(2) The date of rendering of any decision by the Administrator must be no later than 60 days after the date of receipt by the provider of the Board's decision or other reviewable action. The Administrator must promptly send a copy of his or her decision to the Board, to each party to the appeal, to CMS, and, if applicable, to any other affected nonparty.

(3) Any decision by the Administrator may rely on—

(i) Applicable provisions of the law, regulations, CMS Rulings, and other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

(ii) Prior decisions of the Board, the Administrator, and the courts, and any other law that the Administrator finds applicable, whether or not cited in materials submitted to the Administrator.

(iii) The administrative record for the case (as described in § 405.1865 of this subpart).

(iv) Generally known facts that are not subject to reasonable dispute.

(4) A timely decision by the Administrator that affirms, reverses, or modifies one of the Board decisions specified

in paragraph (a)(2) of this section is final and binding on each party to the Board appeal (as described in § 405.1877(a)(4) of this subpart).

(i) If the final Administrator decision follows review of a Board hearing decision, the Administrator's decision is subject to the provisions of § 405.1803(d) of this subpart, unless that final decision is the subject of judicial review (as described in § 405.1877 of this subpart).

(ii) The Administrator, in accordance with §§ 405.1885 through 405.1889 of this subpart, may reopen and revise a final Administrator decision.

(iii) A decision by the Administrator remanding a matter to the Board for further proceedings in accordance with paragraph (f) of this section is not a final decision for purposes of judicial review (as described in § 405.1877(a)(4) of this subpart) or the provisions of § 405.1803(d).

(f) *Remand.* (1) A remand to the Board by the Administrator has the effect for purposes of review—

(i) With respect to a Board decision specified in paragraph (a)(2) of this section, vacating the Board's decision and requiring further proceedings in accordance with the Administrator's decision and this subpart; or

(ii) With respect to a matter described in paragraph (a)(3) of this section, affirming, reversing, modifying, or remanding the Board's remand order, discovery ruling, or subpoena, as applicable, and returning the case to the Board for further proceedings in accordance with the Administrator's decision and this subpart.

(2) The Administrator may direct the Board to take further action for the development of additional facts or new issues, or to consider the applicability of laws or regulations other than those considered by the Board. The following are not acceptable bases for remand:

(i) Presentation of evidence existing at the time of the Board hearing that was known or reasonably may be known.

(ii) Introduction of a favorable court ruling, regardless of whether the ruling was made or was available at the time of the Board hearing or at the time the Board issued its decision.

(iii) Change in a party's representation, regardless when made.

(iv) Presentation of an alternative legal basis concerning an issue in dispute.

(v) Attempted retraction of a waiver of a right, regardless when made.

(3) After remand, the Board must take the actions required in the Administrator's remand order and issue a new decision in accordance with paragraph (f)(1)(i) of this section, or issue under paragraph (f)(1)(ii) of this section an initial decision or a further remand order, discovery ruling, or subpoena ruling, as applicable.

(4) Administrator review of any decision or other action by the Board after remand is, to the extent applicable, subject to the provisions of paragraphs (a)(2) or (a)(3) of this section.

(5) In addition to ordering a remand to the Board, the Administrator may order a remand to any component of HHS or CMS or to a contractor under appropriate circumstances, including, but not limited to, for the purpose of effectuating a court order (as described in § 405.1877(g)(2) of this subpart). When the contractor's denial of the relief, that the provider sought before the Board and that is under review by the Administrator, was based on procedural grounds (such as the alleged failure of the provider to satisfy a time limit) or was based on the alleged failure to supply adequate documentation to support the provider's claim, and the Administrator rules that the basis of the contractor's denial is invalid, the Administrator remands to the contractor for the contractor to make a determination on the merits of the provider's claim.

[73 FR 30262, May 23, 2008; 73 FR 49356, 49357, Aug. 21, 2008, as amended at 80 FR 70602, Nov. 13, 2015; 85 FR 59019, Sept. 18, 2020]

§ 405.1877 Judicial review.

(a) *Basis and scope.* (1) Notwithstanding the provisions of 5 U.S.C. 704 or any other provision of law, sections 205(h) and 1872 of the Act provide that a decision or other action by a reviewing entity is subject to judicial review solely to the extent authorized by section 1878(f)(1) of the Act. This section, along with the EJR provisions of § 405.1842 of this subpart, implements section 1878(f)(1) of the Act.

(2) Section 1878(f)(1) of the Act provides that a provider has a right to obtain judicial review of a final decision of the Board, or of a timely reversal, affirmation, or modification by the Administrator of a final Board decision, by filing a civil action in accordance with the Federal Rules of Civil Procedure in a Federal district court with venue no later than 60 days after the date of receipt by the provider of a final Board decision or a reversal, affirmation, or modification by the Administrator. The Secretary (and not the Administrator or CMS itself, or the contractor) is the only proper defendant in a civil action brought under section 1878(f)(1) of the Act.

(3) A Board decision is final and subject to judicial review under section 1878(f)(1) of the Act only if the decision—

(i) Is one of the Board decisions specified in § 405.1875(a)(2)(i) through (a)(2)(iii) of this subpart or, in a particular case, is deemed to be final by the Administrator under § 405.1875(a)(2)(iv) of this subpart; and

(ii) Is not reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(e) and 405.1875(f) of this subpart within 60 days of the date of receipt by the provider of the Board's decision. A provider is not required to seek Administrator review under § 405.1875(c) first in order to seek judicial review of a Board decision that is final and subject to judicial review under section 1878(f)(1) of the Act.

(4) If the Administrator timely reverses, affirms, or modifies one of the Board decisions specified in § 405.1875(a)(2)(i) through (a)(2)(iii) of this subpart or deemed to be final by the Administrator in a particular case under § 405.1875(a)(2)(iv) of this subpart, the Administrator's reversal, affirmation, or modification is the only decision subject to judicial review under section 1878(f)(1) of the Act. A remand of a Board decision by the Administrator to the Board vacates the decision. Neither the Board's decision nor the Administrator's remand is a final decision subject to judicial review under section 1878(f)(1) of the Act (as described in § 405.1875(e)(4), § 405.1875(f)(1), and § 405.1875(f)(4) of this subpart).

(b) *Determining when a civil action may be filed*—(1) *General rule.* Under section 1878(f)(1) of the Act, the 60-day periods for Administrator review of a decision by the Board, and for judicial review of any final Board decision, respectively, both begin to run on the same day. Paragraphs (b)(2), (b)(3) and (b)(4) of this section identify how various actions or inaction by the Administrator within the 60-day review period determine the scope and timing of any right a provider may have to judicial review under section 1878(f)(1) of the Act.

(2) *Administrator declines review.* If the Administrator declines any review of a Board decision specified in § 405.1875(a)(2) of this subpart, whether through inaction or in a written notice issued under § 405.1875(c)(3) of this subpart, the provider must file any civil action seeking judicial review of the Board's final decision under section 1878(f)(1) of the Act no later than 60 days after the date of receipt by the provider of the Board's decision.

(3) *Administrator accepts review and renders timely decision.* When the Administrator decides to review, in a notice under § 405.1875(c)(3) of this subpart, any issue in a Board decision specified as final, or deemed as final by the Administrator, under § 405.1875(a)(2) of this subpart, and he or she subsequently renders a decision within the 60-day review period (as described in § 405.1875(a)(1) of this subpart), the provider has no right to obtain judicial review of the Board's decision under section 1878(f)(1) of the Act.

(i) If the Administrator timely reverses, affirms, or modifies the Board's decision, the provider's only right under section 1878(f)(1) of the Act is to request judicial review of the Administrator's decision by filing a civil action no later than 60 days after the date of receipt by the provider of the Administrator's decision (as described in § 405.1877(a)(3) of this subpart).

(ii) If the Administrator timely vacates the Board's decision and remands for further proceedings (as described in § 405.1875(f)(1)(i) of this subpart), a provider has no right to judicial review under section 1878(f)(1) of the Act of the Board's decision or of the Administrator's remand (as described in § 405.1877(a)(3) of this subpart).

(4) *Administrator accepts review and timely decision is not rendered.* If the Administrator decides to review, in a notice under § 405.1875(c)(3) of this subpart, any issue in a Board decision specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2), but he or she does not render a decision within the 60-day review period, this subsequent inaction constitutes an affirmation of the Board's decision by the Administrator, for purposes of the time in which to seek judicial review. In this case, the provider must file any civil action requesting judicial review of the Administrator's final decision under section 1878(f)(1) of the Act no later than 60 days after the expiration of the 60-day period for a decision by the Administrator under § 405.1875(a)(1) and § 405.1875(e)(2) of this subpart.

(c) *Statutory limitations on and preclusion of judicial review.* The Act limits or precludes judicial review of certain matters at issue. Limitations on and preclusions of judicial review include the following:

(1) A finding in a contractor determination that expenses incurred for items and services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act, and the regulations at 42 CFR part 411, is not reviewable by the Board (as described in § 405.1840(b)(1) of this subpart) and is not subject to judicial review under section 1878(f)(1) of the Act; the finding is subject to judicial review solely in accordance with the applicable provisions of sections 1155, 1869, and 1879(d) of the Act, and of subpart I of part 405 and subpart B of part 478, as applicable.

(2) Certain matters affecting payments to hospitals under the prospective payment system are completely removed from administrative and judicial review, as provided in section 1886(d)(7) of the Act, and §§ 405.1804 and 405.1840(b)(2) of this subpart.

(3) Any Board remand order, or discovery or disclosure ruling or subpoena specified in § 405.1875(a)(3)(i) through (a)(3)(ii) of this subpart, or a decision by the Administrator following immediate review of a Board remand order,

discovery ruling, or subpoena, is not subject to immediate judicial review under section 1878(f)(1) of the Act. Judicial review of all nonfinal Board actions, including any such Board remand order, discovery or disclosure ruling, or subpoena (except as provided in § 405.1857(e) of this subpart), is limited to review of a final agency decision as described in § 405.1877(a) of this subpart.

(d) *Group appeals.* If a final decision is issued by the Board or rendered by the Administrator, as applicable, in any group appeal brought under § 405.1837, those providers in the group appeal that seek judicial review of the final decision under section 1878(f)(1) of the Act must file a civil action as a group (as described in § 405.1877(e)(2) of this subpart) for the specific matter at issue and common factual or legal question that was addressed in the final agency decision in the group appeal.

(e) *Venue for civil actions*—(1) *Single provider appeals.* A civil action under section 1878(f)(1) of the Act requesting judicial review of a final decision of the Board or the Administrator, as applicable, in a single provider appeal under § 405.1835 of this subpart must be brought in the District Court of the United States for the judicial district in which the provider is located or in the United States District Court for the District of Columbia.

(2) *Group appeals.* A civil action under section 1878(f)(1) of the Act seeking judicial review of a final decision of the Board or the Administrator, as applicable, in a group appeal under § 405.1837 of this subpart must be brought in the District Court of the United States for the judicial district in which the greatest number of providers participating in both the group appeal and the civil action are located or in the United States District Court for the District of Columbia.

(f) *Service of process.* Process must be served as described under 45 CFR part 4.

(g) *Remand by a court*—(1) *General rule.* Under section 1874 of the Act, and § 421.5(b) of this chapter, the Secretary is the real party in interest in a civil action seeking relief under title XVIII of the Act. The Secretary has delegated

to the Administrator the authority under section 1878(f)(1) of the Act to review decisions of the Board and, as applicable, render a final agency decision. If a court, in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter pertaining to Medicare payment to the provider, orders a remand for further action by the Secretary, any component of HHS or CMS, or the contractor, the remand order must be deemed, except as provided in paragraph (g)(3) of this section, to be directed to the Administrator in the first instance, regardless of whether the court's remand order refers to the Secretary, the Administrator, the Board, any other component of HHS or CMS, or the contractor.

(2) *Procedures.* (i) Upon receiving notification of a court remand order, the Administrator must prepare an appropriate remand order and, if applicable, file the order in any Board appeal at issue in the civil action.

(ii) The Administrator's remand order must—

(A) Describe the specific requirements of the court's remand order;

(B) Require compliance with those requirements by the pertinent component of HHS or CMS or by the contractor, as applicable; and

(C) Remand the matter to the appropriate entity for further action.

(iii) After the entity named in the Administrator's remand order completes its response to that order, the entity's response after remand is subject to further proceedings before the Board or the Administrator, as applicable, in accordance with this subpart. For example—

(A) If the contractor issues a revised contractor determination after remand, the provider may request a Board hearing on the revised determination (as described in §§ 405.1803(d) and 405.1889 of this subpart); or,

(B) If the contractor hearing officer(s) or the Board issues a new decision after remand, a decision may be reviewed by a CMS reviewing official or the Administrator, respectively (as described in §§ 405.1834 and 405.1875(f)(4) of this subpart).

(3) *Exception.* The provisions of paragraphs (g)(1) and (g)(2) of this section

do not apply to the extent they may be inconsistent with the court's remand order or any other order of the court regarding the civil action.

(h) *Implementation of final court judgment.* (1) When a final, non-appealable court judgment is issued in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter affecting Medicare payment, a court judgment is subject to the provisions of § 405.1803(d) of this subpart.

(2) The provisions of paragraph (h)(1) of this section do not apply to the extent they may be inconsistent with the court's final judgment or any other order of a court regarding the civil action.

[73 FR 30264, May 23, 2008]

§ 405.1881 Appointment of representative.

A provider or other party may be represented by legal counsel or any other person it appoints to act as its representative at the proceedings, conducted in accordance with §§ 405.1819 and 405.1851.

§ 405.1883 Authority of representative.

A representative appointed by a provider or other party may accept or give on behalf of the provider or other party any request or notice relative to any proceeding before a hearing officer or the Board. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to a request for a contractor hearing or a Board hearing made in accordance with § 405.1811, § 405.1835, or § 405.1837 to the same extent as the party he represents. Notice to a provider or other party of any action, determination, or decision, or a request for the production of evidence by a hearing officer or the Board sent to the representative of the provider or other party shall have the same force and effect as if it had been sent to the provider or other party.

§ 405.1885 Reopening a contractor determination or reviewing entity decision.

(a) *General.* (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to contractor determinations), or by the reviewing entity that made the decision (as described in paragraph (c) of this section).

(i) A specific finding on a matter at issue may be legal or factual in nature or a mixed matter of both law and fact.

(ii) A specific finding on a matter at issue may include a factual matter that arose in or was determined for the same cost reporting period as the period at issue in an appeal filed, or a reopening requested by a provider or initiated by a contractor, under this subpart.

(iii) A specific finding on a matter at issue may include a predicate fact, which is a finding of fact based on a factual matter that first arose in or was first determined for a cost reporting period that predates the period at issue (in an appeal filed, or a reopening requested by a provider or initiated by a contractor, under this subpart), and once determined, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.

(iv) Except as provided for by this section, § 405.1887, and § 405.1889, a specific finding on a matter at issue may not be reopened and, if reopened, revised.

(2) A determination or decision may be reopened either through own motion of CMS (for Secretary determinations), the contractor or reviewing entity, by notifying the parties to the determination or decision (as specified in § 405.1887), or by granting the request of the provider affected by the determination or decision.

(3) A contractor's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.

(4) If CMS directs a contractor to reopen a matter, reopening is considered an own motion reopening by the contractor. A reopening may result in a revision of any matter at issue in the determination or decision.

(5) If a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in § 405.1889 of this subpart.

(6) A determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of this subpart and is not subject to further administrative review or judicial review.

(b) *Time limits*—(1) *Own motion reopening of a determination not procured by fraud or similar fault.* An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887) is sent no later than 3 years after the date of the determination or decision that is the subject of the reopening. The date the notice is sent is presumed to be the date indicated on the notice unless it is shown by a preponderance of the evidence that the notice was sent on a later date.

(2) *Request for reopening of a determination not based on fraud or similar fault.* (i) A reopening made upon request is timely only if the request to reopen is received by CMS, the contractor, or reviewing entity, as appropriate, no later than 3 years after the date of the determination or decision that is the subject of the requested reopening. The date of receipt by CMS, the contractor, or the reviewing entity of the request to reopen is determined by applying the date of receipt presumption criteria for reviewing entities defined in § 405.1801(a), unless it is shown by clear and convincing evidence that CMS, the contractor, or the reviewing entity received the request on an earlier date.

(ii) A request to reopen does not toll the time in which to appeal an otherwise appealable determination or decision.

(iii) A request to reopen that is received within the 3-year period described in this paragraph is timely, notwithstanding that the notice of reopening required under § 405.1887 of this

subpart is issued after such 3-year period.

(iv) The 3-year period described in paragraphs (b)(2)(i) through (b)(2)(iii) of this section applies to, and is calculated separately for, each specific finding on a matter at issue (as described in paragraphs (a)(1)(i) through (a)(1)(iv) of this section, but not to such findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act.

(3) *Reopening of a determination procured by fraud or similar fault.* A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

(c) *Jurisdiction for reopening.* Jurisdiction for reopening a contractor determination or contractor hearing decision rests exclusively with the contractor or contractor hearing officer(s) that rendered the determination or decision (or, when applicable, with the successor contractor), subject to a directive from CMS to reopen or not reopen the determination or decision. Jurisdiction for reopening a Secretary determination, CMS reviewing official decision, a Board decision, or an Administrator decision rests exclusively with CMS, the CMS reviewing official, Board or Administrator, respectively.

(1) *CMS-directed reopenings.* CMS may direct a contractor or contractor hearing officer(s) to reopen and revise any matter, subject to the time limits specified in paragraph (b) of this section, and subject to the limitation expressed in paragraph (c)(2) of this section, by providing explicit direction to the contractor or contractor hearing officer(s) to reopen and revise.

(i) *Examples.* A contractor determination or contractor hearing decision must be reopened and revised if CMS provides explicit notice to the contractor that the contractor determination or the contractor hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established

by CMS in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the contractor. CMS may also direct the contractor to reopen a particular contractor determination or decision in order to implement a final agency decision (as described in §§ 405.1833, 405.1871(b) and 405.1875 of this subpart), a final, non-appealable court judgment § 405.1877, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

(ii) [Reserved]

(2) *Prohibited reopenings.* A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or other interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS, whether made in response to judicial precedent or otherwise, is not a basis for reopening a CMS or contractor determination, a contractor hearing decision, a CMS reviewing official decision, a Board decision, or an Administrator decision, under this section.

(3) *Reopening by CMS or contractor of determination currently on appeal to the Board or Administrator.* CMS or a contractor may reopen, on its own motion or on request of the provider(s), a Secretary or contractor determination that is currently pending on appeal before the Board or Administrator.

(i) The scope of the reopening may include any matter covered by the determination, including those specific matters that are appealed to the Board or the Administrator.

(ii) The contractor must send a copy of the notice required under § 405.1887(a) to the Board or to the Administrator, through the Office of the Attorney Advisor, specifically informing that the matter(s) to be addressed by the reopening is currently under appeal to the Board or to the Administrator or is covered by the same determination that is under appeal.

(4) *Reopening of determination within the time for appealing that determination to the Board.* CMS or a contractor may reopen, on its own motion or on request of the provider(s), a Secretary or contractor determination for which no appeal was taken to the Board, but for

which the time to appeal to the Board has not yet expired, by sending the notice specified in § 405.1887(a) of this subpart.

[73 FR 30265, May 23, 2008, as amended at 78 FR 75195, Dec. 10, 2013; 85 FR 59019, Sept. 18, 2020]

§ 405.1887 Notice of reopening; effect of reopening.

(a) In exercising its reopening authority under § 405.1885, CMS (for Secretary determinations), the contractor or the reviewing entity, as applicable, must provide written notice to all parties to the determination or decision that is the subject of the reopening. Notices of—

(1) Reopening by a CMS reviewing official or the Board must be sent promptly to the Administrator.

(2) Contractor reopenings of determinations that are currently pending before the Board or the Administrator must meet the requirements specified in § 405.1885(c)(3) and (c)(4) of this subpart.

(b) Upon receipt of the notice required under § 405.1887(a) of this subpart, the parties to the prior Secretary or contractor determination or decision by a reviewing entity, as applicable, must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their positions.

(c) Upon concluding its reopening, CMS, the contractor or the reviewing entity, as applicable, must provide written notice promptly to all parties to the determination or decision that is the subject of the reopening, informing the parties as to what matter(s), if any, is revised, with a complete explanation of the basis for any revision.

(d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision (as described in § 405.1889 of this subpart).

[73 FR 30266, May 23, 2008]

§ 405.1889 Effect of a revision; issue-specific nature of appeals of revised determinations and decisions.

(a) If a revision is made in a Secretary or contractor determination or

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a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

[73 FR 30266, May 23, 2008]

Subparts S–T [Reserved]

Subpart U—Conditions for Coverage of Suppliers of End-Stage Renal Disease (ESRD) Services

AUTHORITY: Secs. 1102, 1861, 1862(a), 1871, 1874, and 1881 of the Social Security Act (42 U.S.C. 1302, 1320b–8, 1395x, 1395y(a), 1395hh, 1395kk, and 1395rr), unless otherwise noted.

SOURCE: 41 FR 22511, June 3, 1976, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§§ 405.2100–405.2101 [Reserved]

§ 405.2102 Definitions.

As used in this subpart, the following definitions apply:

Network, ESRD. All Medicare-approved ESRD facilities in a designated geographic area specified by CMS.

Network organization. The administrative governing body to the network and liaison to the Federal government.

[41 FR 22511, June 3, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977, as amended at 43 FR 48950, Oct. 19, 1978; 51 FR 30361, Aug. 26, 1986; 53 FR 6547, Mar. 1, 1988; 55 FR 9575, Mar. 14, 1990; 72 FR 15273, Mar. 30, 2007; 73 FR 20473, Apr. 15, 2008; 79 FR 66261, Nov. 6, 2014]

§ 405.2110 Designation of ESRD networks.

CMS designated ESRD networks in which the approved ESRD facilities

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collectively provide the necessary care for ESRD patients.

(a) *Effect on patient choice of facility.* The designation of networks does not require an ESRD patient to seek care only through the facilities in the designated network where the patient resides, nor does the designation of networks limit patient choice of physicians or facilities, or preclude patient referral by physicians to a facility in another designated network.

(b) *Redesignation of networks.* CMS will redesignate networks, as needed, to ensure that the designations are consistent with ESRD program experience, consistent with ESRD program objectives specified in §405.2101, and compatible with efficient program administration.

[51 FR 30361, Aug. 26, 1986]

§ 405.2111 [Reserved]

§ 405.2112 ESRD network organizations.

CMS will designate an administrative governing body (network organization) for each network. The functions of a network organization include but are not limited to the following:

(a) Developing network goals for placing patients in settings for self-care and transplantation.

(b) Encouraging the use of medically appropriate treatment settings most compatible with patient rehabilitation and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs.

(c) Developing criteria and standards relating to the quality and appropriateness of patient care and, with respect to working with patients, facilities, and providers of services, for encouraging participation in vocational rehabilitation programs.

(d) Evaluating the procedures used by facilities in the network in assessing patients for placement in appropriate treatment modalities.

(e) Making recommendations to member facilities as needed to achieve network goals.

(f) On or before July 1 of each year, submitting to CMS an annual report that contains the following information: