

(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.

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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).

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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