

(ii) The supplier must notify all beneficiaries, who are receiving rented competitive bid items or competitive bid items received on a recurring basis, of the termination of their contract.

(A) The notice to the beneficiary from the supplier must be provided within 15 days of receipt of the final notice of termination.

(B) The notice to the beneficiary must inform the beneficiary that they are going to have to select a new contract supplier to furnish these items in order for Medicare to pay for these items.

(3) *Effect of preclusion.* A supplier who is precluded will not be allowed to participate in a specific round of the Competitive Bidding Program, which will be identified in the original notice of breach of contract, as specified in paragraph (b)(1) of this section.

(4) *Effect of other remedies allowed by law.* If CMS decides to impose other remedies under § 414.422(g)(2)(iv), the details of the remedies will be included in the notice of breach of contract, as specified in paragraph (b)(2) of this section.

[81 FR 77967, Nov. 4, 2016, as amended at 83 FR 57073, Nov. 14, 2018; 84 FR 60809, Nov. 8, 2019]

#### § 414.424 Administrative or judicial review.

(a) There is no administrative or judicial review under this subpart of the following:

(1) Establishment of payment amounts.

(2) Awarding of contracts.

(3) Designation of CBAs.

(4) Phase-in of the competitive bidding programs.

(5) Selection of items for competitive bidding.

(6) Bidding structure and number of contract suppliers selected for a competitive bidding program.

(b) A denied claim is not appealable if the denial is based on a determination by CMS that a competitively bid item was furnished in a CBA in a manner not authorized by this subpart.

[72 FR 18085, Apr. 10, 2007]

#### § 414.425 Claims for damages.

(a) *Eligibility for filing a claim for damages as a result of the termination of sup-*

*plier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).* (1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.

(2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.

(b) *Timeframe for filing a claim.* (1) A completed claim, including all documentation, must be filed within 90 days of January 1, 2010 (the effective date of these damages provisions), unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information required by this rule.

(c) *Information that must be included in a claim.* (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, email address and bidding number, and National Supplier Clearinghouse Number;

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

(5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the

contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.

(d) *Items that will not be considered in a claim.* The following items will not be considered in a claim:

- (1) The cost of submitting a bid.
- (2) Any fees or costs incurred for consulting or marketing.
- (3) Costs associated with accreditation or licensure.
- (4) Costs incurred before March 20, 2008.
- (5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.
- (6) Any profits a supplier may have expected from the contract.
- (7) Costs that would have occurred without a contract having been awarded.
- (8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.
- (9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) *Filing a claim.* (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for damages.

(f) *Review of claim.* (1) *Role of the CBIC.* (i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the

Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and include an explanation that supports its recommendation.

(iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.

(A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.

(B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;

(v) The recommendation will be sent to the Determining Authority for a final determination.

(2) *CMS' role as the Determining Authority.* (i) The Determining Authority shall review the recommendation of the CBIC.

(ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

(iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.

(v) If the Determining Authority non-concurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

(C) Return the claim to the CBIC with further instructions.

(vi) The Determining Authority's determination is final and not subject to administrative or judicial review.

(g) *Timeframe for determinations.* (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.

(2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

(h) *Notification to claimant of damage determination.* The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

[74 FR 62011, Nov. 25, 2009]

**§ 414.426 Adjustments to competitively bid payment amounts to reflect changes in the HCPCS.**

If a HCPCS code for a competitively bid item is revised after the contract period for a competitive bidding program begins, CMS adjusts the single payment amount for that item as follows:

(a) If a single HCPCS code for an item is divided into two or more HCPCS codes for the components of that item, the sum of single payment amounts for the new HCPCS codes equals the single payment amount for the original item. Contract suppliers must furnish the components of the item and submit claims using the new HCPCS codes.

(b) If a single HCPCS code is divided into two or more separate HCPCS codes, the single payment amount for each of the new separate HCPCS codes

is equal to the single payment amount applied to the single HCPCS code. Contract suppliers must furnish the items and submit claims using the new separate HCPCS codes.

(c) If the HCPCS codes for components of an item are merged into a single HCPCS code for the item, the single payment amount for the new HCPCS code is equal to the total of the separate single payment amounts for the components. Contract suppliers must furnish the item and submit claims using the new HCPCS code.

(d) If multiple HCPCS codes for similar items are merged into a single HCPCS code, the items to which the new HCPCS codes apply may be furnished by any supplier that has a valid Medicare billing number. Payment for these items will be made in accordance with Subpart C or Subpart D.

[72 FR 18085, Apr. 10, 2007]

**Subpart G—Payment for Clinical Diagnostic Laboratory Tests**

SOURCE: 71 FR 69786, Dec. 1, 2006, unless otherwise noted.

**§ 414.500 Basis and scope.**

This subpart implements provisions of 1833(h)(8) of the Act and 1834A of the Act—procedures for determining the basis for, and amount of, payment for a clinical diagnostic laboratory test (CDLT).

[81 FR 41098, June 23, 2016]

**§ 414.502 Definitions.**

For purposes of this subpart—

*Actual list charge* means the publicly available rate on the first day the new advanced diagnostic laboratory test (ADLT) is obtainable by a patient who is covered by private insurance, or marketed to the public as a test a patient can receive, even if the test has not yet been performed on that date.

*Advanced diagnostic laboratory test (ADLT)* means a clinical diagnostic laboratory test (CDLT) covered under Medicare Part B that is offered and furnished only by a single laboratory and not sold for use by a laboratory other than the single laboratory that designed the test or a successor owner of