

## § 405.1801

## 42 CFR Ch. IV (10–1–24 Edition)

§ 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, 1395il, 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