

#### § 405.1805

(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

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(§ 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 paragraph (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 decision 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).