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