DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 405, 413, and 417

[CMS–1727–P]

RIN 0938–AL54

Medicare Program; Provider Reimbursement Determinations and Appeals

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: Subpart R of 42 CFR part 405 consists of regulations governing Medicare reimbursement determinations, and appeals of those determinations by health care providers. (For sake of simplicity, through this proposed rule we use ''reimbursement'' to refer to Medicare payment under both the reasonable cost and prospective payment systems.) Under section 1878 of the Social Security Act (the Act) and the regulations, the Provider Reimbursement Review Board (Board) has the authority to adjudicate certain substantial reimbursement disputes between providers and fiscal intermediaries. Board decisions are subject to review by the CMS Administrator, and the final agency decision of the Board or the Administrator, as applicable, is reviewable in Federal district court. In addition, under the regulations, fiscal intermediaries have the authority to hold hearings and adjudicate certain other payment and reimbursement disputes with providers. This proposed rule would update, clarify, and revise various provisions of the regulations governing provider reimbursement determinations, appeals before the Board, appeals before the intermediaries (for lesser disputes), and Administrator review of decisions made by the Board.

DATES: To be assured consideration, comments must be received at the appropriate address, as provided below, no later than 5 p.m. on August 24, 2004.

ADDRESSES: In commenting, please refer to file code CMS–1727–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments to *http://www.cms.hhs.gov/regulations/ecomments* or to *http://www.regulations.gov* (attachments must be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1727–P, P.O. Box 8017, Baltimore, MD 21244–8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7197 in advance to schedule your arrival with one of our staff members.

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850. (Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Morton Marcus, (410) 786–4477.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1727–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS posts all electronic comments received before the close of the comment period on its public website. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone (410) 786–7197.

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I. Background

[If you choose to comment on issues in this section, please include the caption ''Background'' at the beginning of your comments.]

Section 1878(a) of the Social Security Act (the Act) allows providers to appeal to the Board final determinations made by the intermediary under section 1861(v)(1)(A) of the Act (reasonable cost reimbursement), as well as certain determinations by the Secretary involving payment under section 1886(d) (inpatient hospital prospective payment) and section 1886(b) (commonly known as the TEFRA payment system). (See section II.c.1., of this preamble, concerning how we propose to define ''provider.'') In addition, by regulation, providers are given the right to appeal to the Board or intermediary certain other determinations. A brief discussion of the original cost reimbursement, TEFRA, and prospective payment systems (PPS), and some of the types of determinations that are appealable, follows.

For cost reporting years beginning before October 1, 1983, all providers were reimbursed for Part A (hospital insurance) covered items and services they furnished to Medicare beneficiaries on the basis of reasonable cost. Reasonable cost is defined at section 1861(v)(1)(A) of the Act and implementing regulations at 42 CFR, Part 413. In 1982, the Congress determined that the reasonable cost reimbursement system should be modified to provide hospitals with better incentives to render services more efficiently. Accordingly, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. 97–248, the Congress amended the Act by imposing a ceiling on the rate of increase of inpatient operating costs recoverable by a hospital under Medicare.

The Social Security Amendments of 1983 (Pub. L. No. 98–21) added section 1886(d) to the Act, which effective with cost reporting periods beginning on or after October 1, 1983, changed the method of payment for inpatient hospital services under Medicare Part A for short-term acute care hospitals. The method of payment for these hospitals was changed from a cost-based retrospective reimbursement system to a system based on prospectively set rates. Under Medicare's inpatient hospital PPS, payment is made at a predetermined specific rate for each hospital discharge (classified according to a list of diagnosis-related groups (DRGs)), excluding certain costs that continue to be reimbursed under the reasonable cost-based system.

Other statutory changes expanded the types of providers that are subject to a PPS. The Balanced Budget Act of 1997 (BBA), Pub. L. 105–33, established a prospective payment system for home health agencies (HHAs), for rehabilitation hospitals, and for all skilled nursing facilities (SNFs). The Balanced Budget Refinement Act of 1999, Pub. L. 106–113, provided for the establishment of a PPS for long term care hospitals (LTCHs). Although many types of providers are now paid on a prospectively-determined basis, some types of providers, such as hospices, psychiatric hospitals, and children's hospitals continue to be paid on a reasonable cost basis.

Payments to providers are ordinarily made through private organizations known as fiscal intermediaries, under contracts with the Secretary. For covered items and services reimbursed on a reasonable cost basis, the intermediary pays a provider during a cost reporting year interim payments that approximate the provider's actual costs. Under a PPS, providers are generally paid for each discharge after each bill is submitted.

Regardless of whether the provider is paid under reasonable cost or under a PPS, the provider files an annual cost report after the cost year is completed. The intermediary then reviews or audits the cost report, determines the aggregate amount of payment due the provider, and makes any necessary adjustments to the provider's total Medicare reimbursement for the cost year. This year-end reconciliation of Medicare payment for the provider's cost reporting period constitutes an intermediary determination, as defined in § 405.1801(a). Under §§ 405.1801(a)(1) and (2) and 405.1803, the intermediary must render the provider with written notice of the intermediary determination for the cost period in a notice of amount of program reimbursement (NPR). The NPR is an appealable determination.

In addition to the NPR, other determinations made by the intermediary or CMS for hospitals and other providers are appealable to the intermediary or Board (depending on the amount in controversy), such as: a denial of a hospital's request for an adjustment to, or an exemption from, the TEFRA rate of increase ceiling (see § 413.40); a denial of a HHA's or SNF's request for an adjustment to, or an exemption from, the routine cost limits that were in effect prior to a PPS for such providers (see § 413.30); a denial of a PPS hospital's request to be classified as a sole community hospital (see § 412.92) or rural referral center. Also, some health care entities such as renal dialysis facilities, rural health clinics (RHCs) and Federally qualified health centers (FQHCs) are treated as ''providers'' for purposes of subpart R and have appeal rights before the intermediaries and the Board. Thus, for example, a renal dialysis facility may appeal to the intermediary or the Board a CMS denial of its request for an exception to its composite payment rate (see § 413.194(b)).

If a provider is dissatisfied with some aspect of an appealable intermediary or CMS determination, it may request a hearing before the intermediary or the Board, depending on the amount in controversy. For an amount in controversy that is at least $1,000 but less than $10,000, the provider may request an intermediary hearing before the intermediary hearing officer(s) under § 405.1811. If the amount in controversy is at least $10,000, the provider may request a hearing before the Board under section 1878(a) of the Act and § 405.1835 and § 405.1841. Alternatively, the provider may request a Board hearing with one or more additional providers under section 1878(b) of the Act and § 405.1837, if the amount in controversy is, in the aggregate, at least $50,000 (such an appeal is known as a group appeal).

Decisions by the intermediary hearing officer(s) or the Board are subject to further review. Intermediary hearing officers' decisions are subject to review by a CMS reviewing official under section 2917 of the Provider Reimbursement Manual, Part 1, but there is no provision for judicial review of a final decision of the intermediary hearing officer(s) or CMS reviewing official, as applicable. Board decisions are subject to review by the Administrator or the Deputy Administrator of CMS, under section 1878(f)(1) of the Act and § 405.1875. (The Secretary's review authority under section 1878(f)(1) of the Act has been delegated to the Administrator, and redelegated to the Deputy Administrator, of CMS. (For ease of use, throughout this proposed rule we use the term ''Administrator'' to refer to either the Administrator or Deputy Administrator, and the term ''Administrator review'' to review by either official.) A final decision of the Board, or any reversal, affirmance, or modification of a final Board decision by the Administrator, is subject to review by a United States District Court with venue under section 1878(f)(1) of the Act and § 405.1877 of the regulations.

Most of the central provisions of the regulations governing provider reimbursement determinations and appeals are approximately 25 years old. On May 27, 1972 we published a final rule (37 FR 10722), which provided for the intermediary determination, NPR, intermediary hearing, and reopening of both intermediary determinations and intermediary hearing decisions. Five months later, the Congress added section 1878 to the Act, which established the Board and provided for review of Board decisions by the Secretary and for judicial review. (See Social Security Amendments of 1972, Pub. L. 92–603, section 243(a), 86 Stat. 1420 (October 30, 1972). We then, on September 26, 1974 published a final rule (39 FR 34514), that implemented the 1972 amendments to the Act, and revised and redesignated the preexistent rules governing the intermediary determination, NPR, intermediary hearing, and reopening. These regulations were redesignated as subpart R of part 405 of title 42 of the CFR (subpart R) on September 30, 1977 (42 FR 52826). We have revised these regulations on several occasions, largely in response to various amendments to section 1878 of the Act.

For several reasons, we believe it is necessary and appropriate to reexamine many of the subpart R regulations governing provider reimbursement determinations and appeals. As described previously, the principal provisions of the regulations are about 25 years old. In the intervening period, various issues have arisen regarding provider reimbursement determinations and appeals. Important parts of the regulations have been the subject of extensive litigation, the results of which indicate a need for reexamination of the rules. Also important is the development of a backlog of approximately 10,000 cases before the Board. Experience gained through long use of the regulations indicates that

revisions to the regulations would lead to a more effective and efficient appeal process. We believe that the revisions proposed would help the Board reduce the case backlog (or at least forestall substantial additions to it), and would also reflect changes in the statute, clarify our policy on various issues, and eliminate outdated material. Please note that the Provider Reimbursement Review Board's instructions for providers and intermediaries, as well as the Board's decisions on specific cases brought before it, are available on the web at *http://www.hcfa.gov/regs/prrb.htm.*

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption ''Definitions of or Decisions by Entities'' at the beginning of your comments.]

A. Definitions of Entities That Review Intermediary Determinations or Decisions by Such Entities; Definition of Reimbursement (§ 405.1801(a))

1. Intermediary Hearing Officer, CMS Reviewing Official, and CMS Reviewing Official Procedure

As explained above, a provider may appeal the intermediary determination included in the NPR for a cost reporting period to either the intermediary hearing officer(s) or the Board, depending on the amount in controversy. A decision by the intermediary hearing officer(s) may be reviewed by a CMS reviewing official, whereas a Board decision may be reviewed by the CMS Administrator.

Although the term ''intermediary hearing'' is defined in § 405.1801(a) by reference to § 405.1809, the terms ''intermediary hearing officer(s),'' ''CMS reviewing official,'' and ''CMS reviewing official procedure'' are not defined in the regulations. We propose to add to § 405.1801(a) definitions for each of these three terms. The proposed definition of ''intermediary hearing officer(s)'' is ''the hearing officer or panel of hearing officers provided for in § 405.1817.'' The other two terms would be defined by reference to proposed § 405.1834, which is a new section that would add a CMS reviewing official procedure to subpart R. The proposed definition of ''CMS reviewing official'' is ''the reviewing official provided for in § 405.1834.'' In turn, ''CMS reviewing official procedure'' would mean ''the review provided for in § 405.1834.''

2. Administrator Review

We propose to revise the term ''Administrator's review'' in § 405.1801(a) to read ''Administrator review,'' although the current definition of the former phrase would still apply to the new phrase. The current use of the possessive term ''Administrator's'' is unnecessary, and the proposed replacement with the phrase ''Administrator review'' would be consistent with current use of the non-possessive terms ''Board hearing,'' ''intermediary hearing,'' and ''CMS reviewing official procedure.''

3. Reviewing Entity

We propose to add the term ''reviewing entity'' to § 405.1801(a), which would be defined as ''the intermediary hearing officer(s), a CMS reviewing official, the Board, or the Administrator, as applicable.'' We believe that ''reviewing entity'' is an appropriate term for the various entities that can review intermediary determinations (that is, the intermediary hearing officer(s) and the Board) or the entities that can review intermediary hearing officer and Board decisions (that is, a CMS reviewing official and the Administrator, respectively). For example, current §§ 405.1885(a) and (c) provide for reopening of an intermediary determination by the intermediary that made the determination, and reopening of a decision by the administrative body that issued the decision. Current § 405.1885(a) specifies three different decisionmaking bodies as having reopening authority over one of their respective decisions: the intermediary hearing officer(s), the Board, and the Administrator. As a conforming amendment to proposed § 405.1834 (see section II.G. below), we propose to amend § 405.1885(a) to recognize the CMS reviewing official's authority to reopen a prior decision (see section II.V.1. of this preamble). Instead of adding the phrase ''CMS reviewing official'' to the list of decisionmakers with reopening authority under § 405.1885(a), we believe it facilitates ease of reference to use the phrase ''reviewing entity'' in lieu of enumerating all four decisionmakers.

4. Reimbursement

The term ''reimbursement,'' as referring to compensation for providers, appeared in our regulations, and in industry parlance, at a time in which all providers were paid on the basis of their reasonable costs. Upon the development of the inpatient hospital PPS, it became customary for some to use ''payment'' when speaking of remuneration to a hospital covered under the inpatient hospital PPS and ''reimbursement'' when referring to a hospital or other provider covered under the reasonable cost system, whereas others continue to use ''reimbursement'' to refer to compensation under either reasonable cost or a PPS, and still others use the terms interchangeably. We believe it would be verbose, in places where both reasonable cost and a PPS are implicated, to use ''reimbursement or payment.'' Therefore, we propose to define ''reimbursement'' as encompassing compensation under either the reasonable cost or a PPS, so as to make clear that by using ''reimbursment'' we do not mean to exclude providers paid under a PPS or some other payment system.

B. Calculating Time Periods and Deadlines (§§ 405.1801(a) and (d)

[If you choose to comment on issues in this section, please include the caption ''Calculating Time Periods'' at the beginning of your comments.]

1. Basic Proposals

Under section 1878 of the Act and our regulations at 42 CFR, part 405, subpart R, various time periods and deadlines are prescribed for taking specific actions. In addition, the reviewing entities routinely require completion of specific actions within certain time periods or by a specific deadline. We have identified several situations that the present regulations do not specifically address. For example, section 1878(f)(1) of the Act and current § 405.1875(g)(2) authorize the Administrator to review a Board decision within 60 days of when the provider received notification of the Board's decision. Under current § 405.1801(a), the phrase ''date of receipt'' means ''the date on the return receipt of 'return receipt requested' mail, unless otherwise defined.'' The regulations do not address, however, how to determine the date of provider receipt under § 405.1875(g)(2) if a Board decision is not sent by return receipt requested mail, the provider does not return or date any receipt, or the return receipt certificate is destroyed or obscured. The potential for uncertainty seems greater for material exchanged between providers and intermediaries because experience indicates they do not use return receipt mail regularly.

Similarly, the various reviewing entities routinely issue orders requiring that certain actions be taken within a prescribed time period. (For example, the Board may require submission of position papers within 90 days of an order.) Section 405.1801(a) defines ''date of filing'' and ''date of submission of materials'' to mean ''the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless

otherwise defined in this subpart.'' However, the regulations do not address how to determine the date of submission (or filing) of materials where, for example, the envelope containing a Board order is destroyed or lost, has no postmark, or has an obscured postmark.

The current regulations also do not address how to determine the first, subsequent, and last days of a prescribed time period. For example, no provision in subpart R addresses how to determine the end of a designated time period when the last day of the period is a Saturday, Sunday, Federal legal holiday, or other nonwork day for Federal employees.

Accordingly, we believe it is necessary and appropriate to revise our regulations at subpart R to ensure that providers, reviewing entities and others may determine precisely the various time periods and deadlines imposed by section 1878 of the Act, the regulations, and particular orders of a reviewing entity. In order to meet this objective, we propose to remove the current definitions in § 405.1801(a) of ''date of filing'' and ''date of submission of materials'' and instead provide specific provisions that address the time to appeal a determination or decision of an intermediary, the Board or the Administrator. Thus, proposed § 405.1811(a)(3) would specify the time to request an intermediary hearing; proposed § 405.1834(c) would explain the time to request review by a CMS reviewing official of an intermediary hearing officer decision; proposed § 405.1835(a)(3) would state the time to request a Board hearing; and proposed section 1875(c)(1) would specify the time to seek Administrator review. Likewise, proposed § 405.1875(e)(2) would specify the time the Administrator must render a decision (where the Administrator has taken review of a Board decision or other reviewable Board action), and proposed section 405.1877(b) would state the time a provider may request judicial review of a final Board or Administrator decision. As a general matter, we propose to calculate the beginning period that a party has to take action with reference to the date the party received the triggering notice, and we propose to calculate the end of the period that the action must be taken with reference to the date the reviewing entity must receive the party's submission. (We are using ''party'' in the previous sentence in a non-technical sense.) Also, generally throughout the preamble and the text of this proposed rule we avoid using the phrase ''within x days'' and instead use ''no later than x days after'' in order to make clear that the party or reviewing entity has the benefit of the last day of the period specified. Where the language ''within'' is used (because it would be cumbersome to say ''no later than'') it should be understood that the party or reviewing entity has the benefit of the last day of the period specified.)

Accordingly, we propose to revise the current definition of ''date of receipt'' in § 405.1801, and we propose to add a new paragraph (d) to § 405.1801, which would prescribe rules for determining the first, subsequent, and last days of a designated time period.

2. Definition of ''Date of Receipt''

We propose to revise the definition for ''date of receipt'' as the date a document or other material is received. As part of the proposed definition, we would specify how we determine when a document or other material is received by: (1) a party or non-party involved in proceedings before a reviewing entity; and (2) a reviewing entity.

a. Determining Date of Receipt by Parties and Non-Parties Involved in Proceedings Before a Reviewing Entity—Use of 5-Day Presumption

Under our proposal, we would establish the presumption that the receipt date of documents or other materials sent to providers, intermediaries, and other entities involved in proceedings is 5 days after the postmark date. The presumption would apply to documents and other materials sent by the reviewing entity to parties and non-parties as well as to those sent from one party or non-party to another party or non-party. However, this presumption would be rebutted if a preponderance of the relevant evidence established that the intermediary notice, reviewing entity document, or submitted material, as applicable, was actually received on a later date. The proposed definition further states that the phrase ''date of receipt'' in the definition is, as applied to a provider, synonymous with the term ''notice'' in section 1878 of the Act and in subpart R.

We believe this definition is necessary and appropriate in order to facilitate accurate determinations of the date of receipt by parties and affected nonparties of documents and materials pertaining to reviewing entity proceedings. Furthermore, as discussed below with respect to § 405.1835(a)(3) (see section II.D.3. of this preamble), we believe the proposed definition is appropriate given the apparent need to dispel potential confusion about when the 180-day period for submitting a Board appeal begins to run. Under proposed § 405.1835(a)(3), we would interpret the references to notice in section 1878(a)(3) of the Act and in subpart R to mean that the 180-day appeal period commences on the date of receipt by the provider of the NPR for the intermediary determination or, where applicable, upon the expiration of the 12-month period for issuance of the NPR. Our proposal that the phrase ''date of receipt'' in this definition is, as applied to a provider, synonymous with the word ''notice'' in section 1878 of the Act, facilitates our new interpretation of the 180-day appeal period prescribed in section 1878(a)(3) of the Act and in the regulations.

Our proposal to determine the presumed receipt date of a document or other material through a ''5-day convention'' is premised on several factors. Use of a time period convention would avoid any problem of verifying when a document or other material is actually received, except where evidence is presented to rebut the presumed 5-day period. Also, use of a 5-day period as the presumed receipt date would be similar to our policies for reconsideration and appeal for an individual under Medicare Part A (see § 405.722), and for reconsideration and appeal of determinations affecting participation in the Medicare program (see § 498.22(b)(3) and § 498.40(a)(2)), and it would ensure enough time for the period typically necessary for receipt of first class, United States mail.

Also, we believe our proposal to allow for rebuttal of the 5-day convention for determining the receipt date provides an adequate means for a provider, or any entity involved in reviewing entity proceedings to establish that it actually received a document or other material on a later date. We propose to limit the rebuttal opportunity to a satisfactory showing of actual receipt on a date *later* than the presumed date, due to the need for the intermediary (in the case of intermediary notices) or a reviewing entity to know in advance that the prescribed period for taking a given action commences no earlier than a date certain. For example, in order to ensure compliance with the 60-day period for Administrator review of a Board decision under section 1878(f)(1) of the Act and § 405.1875, the Administrator must know in advance that the review period commences no earlier than a date certain. We believe it is reasonable to permit a provider to establish actual receipt of a Board decision after the presumed 5-day period ends, because the Administrator would still be able to render a timely decision. But if we permit the provider to establish actual

receipt before the presumed 5-day period ends, the Administrator might not have enough remaining time to meet the 60-day deadline.

b. Determining Date of Receipt by Reviewing Entity—Presumption of Date Stamp

For materials submitted to a reviewing entity, we would establish the presumption that the receipt date is the date the reviewing entity (or its substitute, see following paragraph) stamped ''Received'' on the document or other submitted material. The presumption would be rebutted if a preponderance of the relevant evidence established that the document or other submitted material was actually received on a different date by the reviewing entity.

For intermediary hearings where the intermediary hearing officer has not yet been appointed or is not presiding currently, the date of receipt by the intermediary hearing officer would be determined by the date stamped ''Received'' by the intermediary. In other words, the intermediary would act as a substitute for the intermediary hearing officer for this purpose. Similarly, we propose to determine receipt date by a CMS reviewing official or the CMS Administrator by reference to the date stamped ''Received'' by CMS's Office of the Attorney Advisor because that Office would seem to be the appropriate recipient in light of the Administrator's many other duties, and because the proposal is consistent with our longstanding practice (see 59 FR 14628, 14645 (March 29, 1994) for a description of the Office of the Attorney Advisor).

Our proposal to use the date a document or other material is received by the reviewing entity is based on the presumption of administrative regularity in agency action. In view of that presumption, it seems reasonable to have our proposed definition presume that the receipt date is the date the reviewing entity or its substitute stamped ''Received'' on the document or other submitted material. We also believe reasonable our proposal that the presumed receipt date may be rebutted if a different date of receipt is established by a preponderance of the relevant evidence. Given the presumption of administrative regularity, we considered proposing use of the stricter standard of clear and convincing evidence, but rejected this alternative for the sake of consistency and ease of application. That is, as discussed above, the preponderance of the relevant evidence standard would apply for purposes of establishing that a provider or entity received a document on a date other than the presumed receipt date, and the preponderance of the evidence standard seems easier to apply than the clear and convincing evidence standard.

3. Determining Specific Days in Calculating Time Periods and Deadlines

We propose to add a new paragraph (d) to § 405.1801 in order to facilitate the determination of the first, subsequent, and last days included in a time period prescribed or allowed under section 1878 of the Act or subpart R or authorized by a reviewing entity. As to the first day of such a period, the day of the act, event, or default from which the designated time period begins to run would be excluded from the period under proposed paragraph (d)(1).

Proposed paragraph (d)(2) provides that, with two exceptions, each succeeding calendar day, including the last day, would be included in the time period. The first exception is that, for an act to be performed by a reviewing entity, a calendar day would be excluded if the intermediary (for purposes of an intermediary notice) or the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control (for example, natural or other catastrophe, weather conditions, fire, or furlough). In such cases, the designated time period would resume on the next work day the intermediary or reviewing entity is again able to conduct business in the usual manner.

The second exception proposed under paragraph (d)(2) is that the last day of the designated time period would be excluded if it is a Saturday, Sunday, Federal legal holiday, other nonwork day for Federal employees, or, in the case of a deadline for submission of material to the intermediary (for purposes of an intermediary notice) or a reviewing entity, a day when the intermediary or reviewing entity is not conducting business. In the case of any such excluded day, the designated time period would continue to run until the end of the next day that is not one of the above-described days. Furthermore, paragraph (d)(4) would provide that a reviewing entity is, for purposes of paragraph (d), deemed to be the intermediary in the absence of duly appointed and presiding intermediary hearing officer(s), and to include, in the context of review by a CMS reviewing official or the Administrator, the Office of the Attorney Advisor.

We believe the proposed addition of paragraph (d) to § 405.1801 is necessary and appropriate to ensure the accurate determination of the specific days to be included in the calculation of a time period or deadline prescribed under section 1878 of the Act, subpart R, or by a reviewing entity. Also, we believe that proposed paragraph (d) will accomplish these objectives because much of that paragraph seems reasonably based on and adapted from other authorities. Specifically, proposed paragraphs (d)(1) and (d)(3) are adapted from the first and second sentences of Rule 6(a) of the Federal Rules of Civil Procedure, which address the same kinds of problems for civil actions. Also, proposed paragraph (d)(3) is authorized by sections 216(j) and 1872 of the Act.

Proposed paragraph (d)(2) reflects our concern that a prolonged period in which an intermediary (as to intermediary notices) or a reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control could result in the intermediary or reviewing entity being required to take action on numerous matters immediately after the prolonged period of inactivity. For example, the intermediary could be required to issue numerous NPRs, and/or a reviewing entity might have to render multiple decisions on the first business day after the work interruption. In fact, the Board and the Administrator were confronted with similar problems at the end of a prolonged furlough of Federal employees in late 1995 and early 1996. We believe proposed paragraph (d)(2) would eliminate this problem by requiring that a designated time period would be suspended for as long as the intermediary or reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control. Extraordinary circumstances would be defined as circumstances such as natural or other catastrophe, weather conditions, fire, or furlough.

Finally, in proposed paragraph (d)(4) we would provide that, for purposes of paragraph (d), a reviewing entity would include an intermediary in the situation where an intermediary officer has not yet been appointed (or if appointed, is not yet presiding), and would also include the Office of the Attorney Advisor.

C. Providers Under Subpart R; Limited Applicability to Non-Provider Entities (§ 405.1801(b))

1. Providers

Current § 405.1801(b)(1) states that the term ''provider'' includes, for purposes of subpart R, hospitals paid under the PPS. However, neither

§ 405.1801(b)(1) nor any other regulation identifies all of the entities that constitute providers under subpart R.

We believe it is necessary and appropriate to identify all of the entities that qualify as a provider for purposes of subpart R. Sections 1861(u), 1878(j), and 1881(b)(2)(D) of the Act recognize various types of entities as providers for purposes of provider reimbursement determinations and appeals. By collecting and enumerating the various types of providers in one regulation, we believe the potential for confusion about this matter can be forestalled. Thus, we propose to amend § 405.1801(b)(1) to recognize as a provider under subpart R each entity recognized under the Act for purposes of provider reimbursement determinations and appeals.

In accordance with the definition of ''provider of services'' in section 1861(u) of the Act, we propose to recognize specifically a hospital, critical access hospital (CAH), SNF, comprehensive outpatient rehabilitation facility (CORF), HHA, and hospice program. Also, a RHC and a FQHC would be included in accordance with section 1878(j) of the Act, and an end stage renal disease (ESRD) facility would be recognized under section 1881(b)(2)(D) of the Act. Our proposed revision to § 405.1801(b)(1) would also recognize as a provider any other entity treated as a provider under the Act, in order to ensure recognition in subpart R of any other entity that may qualify as a provider under the Act for purposes of provider reimbursement determinations and appeals.

2. Non-Provider Entities

Current § 405.1801(b)(2) addresses entities that do not qualify as providers under the Act, but which are reimbursed on the basis of information included in required cost reports. Such non-provider entities include health maintenance organizations (HMOs) and competitive medical plans (CMPs). Section 405.1801(b)(2) states that such non-provider entities do not qualify for Board review, but that the rules in subpart R regarding intermediary hearings ''are applicable to the [non-provider] entities to the maximum extent possible'' where the amount of program reimbursement in controversy is at least $1,000.

We believe § 405.1801(b)(2) needs clarification and revision as to the specific applicability of subpart R to non-provider entities. We believe the regulation is incomplete in stating that non-provider entities do not qualify for a Board hearing. Under our longstanding policy, these entities cannot qualify for a Board hearing or an intermediary hearing because both types of hearings are available only to providers. (We note that non-provider entities such as HMOs and CMPs may instead have a right to a hearing before a CMS reviewing official if the amount in controversy is at least $1,000.) Thus, we propose to revise § 405.1801(b)(2) to state that non-provider entities may not obtain an intermediary hearing or a Board hearing.

We believe § 405.1801(b)(2) further states that rules for intermediary hearings are applicable to non-provider hearings ''to the maximum extent possible'' also needs clarification. It is our longstanding policy that only the procedural rules in subpart R apply to non-provider hearings before a CMS reviewing official. In addition, we believe that non-provider hearings before a CMS reviewing official are more analogous to a Board hearing than an intermediary hearing. For example, non-provider hearings before a CMS reviewing official are adversarial, which is also true of Board hearings (see § 405.1843) but not intermediary hearings (see § 405.1815). Accordingly, we propose to revise § 405.1801(b)(2) to state that if a hearing is available to a non-provider entity on an amount in controversy of at least $1,000, the procedural rules for a Board hearing under this subpart are applicable to the maximum extent possible. The phrase ''procedural rules'' in proposed § 405.1801(b)(2) would have the same meaning as the phrase ''rules of agency organization, procedure, or practice'' in the Administrative Procedure Act, 5 U.S.C. § 553(b)(3)(A).

D. Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)

[If you choose to comment on issues in this section, please include the caption ''Provider Hearing Rights'' at the beginning of your comments.]

Under section 1878(a) of the Act and §§ 405.1835 and 405.1841 of the regulations, a provider may obtain a Board hearing if it meets three jurisdictional requirements: (1) The provider is dissatisfied with its Medicare reimbursement for a cost reporting period; (2) the amount in controversy is at least $10,000 (at least $50,000 for a group appeal); and (3) the provider files a timely request for a hearing to the Board. The same jurisdictional requirements govern provider requests for an intermediary hearing under § 405.1811, except the amount in controversy requirement is $1,000 or more but less than $10,000.

For the reasons set forth in this section, we believe it is necessary and appropriate to revise the regulations in subpart R governing provider hearing requests. We discuss the first and third jurisdictional requirements below, and address the amount in controversy requirement separately for § 405.1839 in section II. I. of this preamble.

1. Provider Dissatisfaction With Medicare Reimbursement; Revised Self-Disallowance Policy

Section 1878(a)(1)(A) of the Act authorizes a provider to obtain a Board hearing if the provider is dissatisfied with a final determination by: (i) the intermediary, of the total amount of program reimbursement for a cost reporting period, or (ii) the Secretary, as to the amount of payment under sections 1886(b) or (d) of the Act. (We note that the references to ''final determination'' in section 1878(a)(1)(A) of the Act are reflected in § 405.1801(a)(1) through (a)(3) and § 405.1803 of the regulations, which require the intermediary to issue to the provider a written NPR reflecting the intermediary determination for the cost reporting period.) Provider dissatisfaction with Medicare reimbursement is also a requirement for a hearing before the intermediary and the Board under §§ 405.1811(b) and § 405.1841(a)(1), respectively. Under our original policy, we required a provider to make a specific claim for an item on its cost report as a prerequisite to appeal. That is, under that policy, a provider that did not claim an item on its cost report did not meet the dissatisfaction requirement for purposes of obtaining an intermediary or Board hearing. We did not permit a provider to ''self-disallow'' an item (even if the intermediary had no discretion to award payment for the item) and then seek an appeal before the Board.

Several court decisions addressed our original self-disallowance policy, culminating in the Supreme Court's decision in *Bethesda Hospital Association* v. *Bowen,* 485 U.S. 399 (1988). The providers in the *Bethesda* case self-disallowed their malpractice insurance costs by submitting cost report claims that complied with a regulation, and seeking additional reimbursement before the Board. The Board dismissed the providers' appeal for lack of jurisdiction based on the self-disallowance policy. The Supreme Court held that the plain language of the dissatisfaction requirement in section 1878(a)(1)(A) of the Act supported Board jurisdiction under the facts of the case. The Court reasoned that the intermediary had no authority to award

reimbursement in excess of the regulation by which it was bound, and that it would be futile for a provider to try to persuade the intermediary otherwise.

Following the *Bethesda* decision, we no longer required providers to claim items for which the intermediary did not have the discretion to award payment due to a regulation or manual provision. (See former Appendix A, § B.1. of the Provider Reimbursement Manual (PRM)). We believe it is appropriate to codify our policy in regulations and we are taking this opportunity to make the following proposals. We propose to include, as an interpretation of the dissatisfaction jurisdictional requirement, our self-disallowance policy in a revised § 405.1811(a)(1) and § 405.1835(a)(1) for intermediary and Board hearings, respectively.

Under our proposal, in order to preserve its appeal rights, a provider must either claim an item on its cost report where it is seeking reimbursement that it believes to be in accordance with Medicare policy, or self-disallow the item where it is seeking reimbursement that it believes may not be in accordance with Medicare policy (for example, where the intermediary does not have the discretion to award the reimbursement sought by the provider). In order to self-disallow an item, the provider would be required to follow the applicable procedures for filing a cost report under protest, which are contained currently in § 115 of the PRM, Part 2 (CMS Pub. 15–2). Note that we are using the term ''item'' instead of ''cost'' to emphasize that our proposed policy would refer to determinations of amounts due to providers subject to a prospective system as well as determinations of reimbursement due to providers that are paid under cost reimbursement principles.

We believe the self-disallowance rule proposed in § 405.1811(a)(1)(i) and § 405.1835(a)(1)(i) is appropriate under the *Bethesda* decision. We further believe that our proposed policy is a reasonable response to statements by the *Bethesda* providers and others that it is necessary, for any reimbursement request in excess of the amount allowed under program policy, to raise the entire payment request before the Board, because it would be improper to include a cost report claim for more payment than is permitted by Medicare policy. It has been our longstanding policy that a cost report claim at variance with Medicare policy is not improper, provided that such a claim is not intended to procure an intermediary determination (or reviewing entity decision) by fraud or similar fault. For example, given that the *Bethesda* providers' request for additional reimbursement before the Board was premised on their disagreement with and challenge to a reimbursement regulation, it would not have been improper for them to include cost report claims in conformity with their good-faith view as to the proper amount of reimbursement.

2. Audits of Self-Disallowed Items

Under our proposed policy regarding self-disallowed costs, the amount of any cost report claim or intermediary disallowance may differ from the amount of reimbursement requested through a Board or intermediary hearing. Intermediary audits of provider items are usually limited to items included in a cost report, which presumably would often exclude self-disallowed items. Thus, in cases where a provider self-disallows an item by foregoing any cost report claim (or including less than a full claim) and appealing to the Board or intermediary, we would expect such self-disallowed items to be unaudited.

We believe the likelihood that self-disallowed items are unaudited is reason for concern in the event of reviewing entity decisions, court judgments, and settlement agreements that require payment of self-disallowed items. Specifically, in cases where a self-disallowed item is held reimbursable in a final decision by a reviewing entity or a final, non-appealable court judgment, the intermediary might pay the provider for unaudited self-disallowed items. The same problem could develop where an administrative or judicial settlement agreement requires payment of a self-disallowed item. We believe that these results may prove inappropriate in specific cases.

We believe that, given the potential for inappropriate payment of unaudited self-disallowed items, it is necessary and appropriate to provide for intermediary audits of these items. Thus, we propose to add a new paragraph (d) to § 405.1803, which would authorize CMS to require intermediary audits of self-disallowed items before these items may be paid according to a final agency decision, a final, non-appealable court judgment, or an administrative or judicial settlement agreement. Proposed § 405.1803(d) would further provide that CMS's authority to require audits of self-disallowed items is inapplicable to the extent such audits would be inconsistent with a governing court order or settlement agreement.

3. Determining Timeliness of Hearing Requests (§§ 405.1811 and 1835)

Section 1878(a)(3) of the Act requires a provider to file any request for a Board hearing within 180 days ''after notice'' of a final determination by an intermediary or the Secretary. Moreover, section 1878(a)(1)(B), (C), and (a)(3) of the Act require that, in the absence of a timely final determination, a Board hearing request must be filed within 180 days ''after notice'' of such determination ''would have been received'' if the determination had been made on a timely basis. Under current § 405.1835(a)(2) and § 405.1841(a)(1) of the regulations, any request for a Board hearing must be filed with the Board within 180 days of the date the NPR was mailed to the provider. Also, current § 405.1835(c) and § 405.1841(a)(1) provide that if an NPR is not issued within 12 months of the intermediary's receipt of an appropriate cost report, then any hearing request must be filed with the Board within 180 days after the expiration of the 12 month period for a timely NPR. Comparable requirements apply under § 405.1811(a) for purposes of determining the timeliness of a provider request for an intermediary hearing.

We believe it is necessary to revise the regulations governing the timeliness of hearing requests before the Board and intermediary. There is some potential for confusion in determining the 180-day appeal period, especially as to the beginning date of the period. For example, for Board appeals from a timely NPR, section 1878(a)(3) of the Act states that the period commences ''after notice'' of the final determination, but does not specify how to determine the date of such notice. For Board hearings, the beginning date under § 405.1841(a)(1) is the date the NPR is mailed to the provider. But under § 405.1811(a), the date of the NPR starts the period for intermediary hearing requests.

In our opinion, the references in section 1878(a)(3) of the Act to ''after notice'' are ambiguous as to the beginning date for the 180-day period for Board hearing requests. We believe the statute can be interpreted reasonably to permit use of any of the following events as the beginning date: the date the provider receives the final determination; the mailing date of the determination; and, the date of the determination.

We propose to revise the regulations to provide that the 180-day period for requesting a Board or intermediary

hearing begins on the date of receipt by the provider of the intermediary determination or, where applicable, the expiration date of the 12-month period for issuance of a timely NPR by the intermediary. These proposed revisions are premised in part on our belief that it is unnecessary for the beginning date of the 180-day period to be determined differently for hearing requests to the intermediary (that is, the NPR date) and the Board (that is, the NPR mailing date). Although we considered the three alternatives of receipt date, NPR date, and NPR mailing date, our proposed use of receipt date is based on several factors.

We believe the proposed use of receipt date is consistent with the reference in section 1878(a)(3) of the Act to when an untimely final determination ''would have been received,'' and to the various references to receipt date in section 1878(f)(1) of the Act and current § 405.1875 and § 405.1877 pertaining to the beginning date of the 60-day period for Administrator and judicial review. Also, determining the beginning date of the 180-day appeal period by reference to receipt date is consistent with our more general proposal in § 405.1801(a) to redefine the phrase ''date of receipt'' as applied to a provider, as discussed in section II.B.2.a. of this preamble. Moreover, under the 5-day convention for determining date of receipt under our proposed definition, the provider likely would have the NPR in hand by the proposed beginning date of the 180-day appeal period. Thus, the beginning date of the 180-day appeal period would probably be a day on which the provider could actually start to determine whether to request a hearing.

Our proposal also includes a different means of determining the ending date of the 180-day appeal period. Under current § 405.1811(a)(1) and § 405.1841(a)(1), the ending date is the date of filing with the intermediary or Board, respectively, which is determined under § 405.1801 by reference to the date of mailing or hand delivery of the hearing request. We propose to determine the ending date of the appeal period by the date the intermediary or Board received the hearing request. As discussed in II.B.2.b. of this preamble, the date a reviewing entity receives a hearing request or other document is presumed to be the date stamped ''Received.''

We believe that the proposed use of receipt date by the Board or intermediary is consistent with the reference in section 1878(a)(3) of the Act to ''provider files a request for a hearing.'' The word ''file'' is defined in *Black's Law Dictionary* in terms of depositing material in the custody or among the records of a court, and delivering material to the proper official for filing as a matter of record. Determining the ending date of the 180-day appeal by reference to when the Board or intermediary receives the hearing request comports with this definition and the usual practice of the courts. Also, given our proposal to determine the beginning date by reference to provider receipt date, we believe the proposed use of Board or intermediary receipt date to determine the ending date is an appropriate corresponding change.

4. Contents of Hearing Request

Under § 405.1811(a) and (b) (for an intermediary hearing) and § 405.1835(a)(2) and § 405.1841(a)(1) (for a Board hearing), a hearing request must be in writing and must identify the specific aspects of the intermediary determination with which the provider is dissatisfied, explain its dissatisfaction with each matter at issue, and submit supporting documentation for its position on each matter at issue. We believe it is necessary and appropriate to revise the regulations governing the content of provider hearing requests for three reasons.

First, we believe the extensive litigation of various issues of Board jurisdiction is attributable in part to the absence of regulations requiring an early and continuing focus on whether the Board has jurisdiction over each matter at issue. Although we address this problem in detail with respect to our proposed addition of new § 405.1814 (''Intermediary hearing officer jurisdiction'') and § 405.1840 (''Board jurisdiction''), as discussed in sections II.F. and II.J. of this preamble, we believe it is necessary to propose corresponding changes to other regulations. In order to facilitate an early focus by the parties and the reviewing entity on the jurisdictional requirements for a hearing before the Board or intermediary, we believe it is reasonable to require the original hearing request to include a demonstration (through argument and supporting documentation) that the provider satisfies the jurisdictional requirements for the hearing request. Accordingly, we propose in § 405.1811(b)(1) and § 405.1835(b)(1) to require the provider to demonstrate in its hearing request (through argument and supporting documentation) that it meets the requirements for a hearing before the intermediary or the Board, respectively. We believe this proposal will facilitate the reviewing entity's capacity to meet its continuing responsibility to ensure its own jurisdiction throughout each stage of the proceedings (see § 405.1814 and § 405.1840).

Second, we also believe it is necessary to revise the current requirement that a provider identify, explain, and document its dissatisfaction with particular aspects of the intermediary determination. In order to facilitate the reviewing entity's capacity to determine compliance with our proposed self-disallowance rules, we believe it is reasonable to require the hearing request to include a description of the nature and amount of each self-disallowed item and the reimbursement sought for each cost. In proposed § 405.1811(b)(2) and § 405.1835(b)(2), we would include this requirement in addition to the current requirement that the provider identify and explain its dissatisfaction with each matter at issue in the hearing request. We also note that the proposed requirement of detailed information about each specific self-disallowed item should help the intermediary conduct any audits of self-disallowed items that may be required under proposed § 405.1803(d), as discussed in section II.D.2. of this preamble.

Third, we further believe it is necessary to clarify the current requirement that a hearing request include supporting documentary evidence. We are aware of various cases in which the need to determine Board jurisdiction over a specific matter at issue has been hampered by the absence of the NPR(s) relevant to the appeal or by confusion about whether the NPR at issue was the initial NPR or a revised NPR issued after reopening (see § 405.1885 and § 405.1889). Because appropriate findings of fact and conclusions of law about Board jurisdiction (see proposed § 405.1840) cannot be reached without this information, proposed § 405.1811(b)(3) and § 405.1835(b)(3) would require the hearing request to include each intermediary determination at issue in the appeal. (We note that if the intermediary determination under appeal is a revised NPR, the provider would be required to include the pertinent reopening notice and the initial NPR so that an appropriate determination can be made as to whether a specific matter at issue is within the scope of the revised NPR.) For similar reasons, the hearing request would have to include all documents necessary to determine compliance with the self-disallowance rules proposed in § 405.1811 and § 405.1835. However, the hearing request would no longer need to include documents necessary to

support the merits of the provider's position on a specific reimbursement matter because the reviewing entity must make a preliminary finding of its jurisdiction over each matter at issue before it considers the merits of a particular issue (see proposed § 405.1814 and proposed § 405.1840).

5. Adding Issues to Original Hearing Request (§ 405.1811(c) and § 405.1835(c))

Under current § 405.1811(c) and § 405.1841(a)(1), a provider may add a specific matter at issue to the original request for a hearing before the intermediary or the Board, respectively, anytime before the commencement of a hearing. Under our longstanding interpretation of these provisions, a provider's right to add issues is limited to a single provider appeal before the Board or the intermediary, and does not apply to a group appeal to the Board under section 1878(b) of the Act and § 405.1837. Also, a provider's right to add issues is contingent on an original hearing request that meets all jurisdictional requirements for a Board or intermediary hearing, along with satisfaction of applicable jurisdictional requirements after any issues are added to the original request. Moreover, if a provider's original hearing request is an appeal from a revised NPR issued after a reopening (see § 405.1885 and § 405.1889), the provider's right to add issues is limited to those specific matters that are within the scope of the reopening and revised NPR.

We believe it is necessary to revise the regulations governing the addition of issues to an original hearing request. At the time the current provisions were adopted in September, 1974, there was no case backlog at the Board; thus, it was reasonable to expect that hearings would be conducted expeditiously, thereby leaving a relatively short period for the addition of new issues. As the case backlog and the period before the hearing have increased, however, it has become apparent that permitting the addition of issues at any time before the hearing is untenable. Because Board hearings often are not conducted until several years after the original hearing request, the period for adding issues far exceeds our original expectations. Moreover, we believe the availability of such a long period for adding issues has become a major obstacle to the Board's efforts to reduce (or at least minimize additions to) its case backlog.

In order to resolve (or at least mitigate) the problems posed by a virtually open-ended period for adding issues, we believe it is appropriate to propose a period that reconciles a provider's potential need to supplement its original hearing request with the imperative of enhancing the Board's capacity to reduce the case backlog. We believe a 60-day period, commencing with the expiration of the applicable 180-day period for submitting the original hearing request under proposed § 405.1811(a)(3) and § 405.1835(a)(3), would strike an appropriate balance between these two concerns. On the one hand, a 60-day period should foreclose additions to the case backlog that are attributable to the addition of new issues to appeals that may remain pending before the Board for several years.

However, a 60-day period would afford providers an adequate opportunity to appeal specific issues that were overlooked in the original hearing request. A provider has at least 5 months after the end of a fiscal period to file a cost report (see § 413.24(f)(2)), after which the intermediary has 12 months to issue a timely NPR (see § 405.1835(c)). Of course, the provider then has 180 days in which to analyze the NPR and prepare and submit any hearing request. Our proposal to allow 60 more days for the addition of new issues to the original hearing request gives the provider ample time to appeal any matter overlooked in the original hearing request.

We believe a proposed 60-day limitation on the period for adding issues to an original hearing request is consistent with section 1878 of the Act. This provision does not address whether or how long a provider may add issues to a pending request for a Board hearing. Nonetheless, we considered whether our proposal is consistent with section 1878(d) of the Act, which gives the Board the power to affirm, modify, or reverse the intermediary determination under appeal, and to make any other revisions on matters covered by the cost report regardless of whether such matters were considered by the intermediary in making the final determination of Medicare reimbursement.

We believe that, in cases where the Board has jurisdiction under section 1878(a) of the Act, section 1878(d) does not foreclose our proposed 60-day period for adding issues. We recognize that, to the extent the Board has jurisdiction under section 1878(a) over a single provider appeal from an initial NPR, the third sentence of section 1878(d) confers on the Board the power to affirm, modify, or reverse the intermediary determination, and to make any other revisions on matters covered by the cost report regardless of whether such matters were considered by the intermediary in making the final determination. However, we interpret this provision to address only the Board's powers over a jurisdictionally proper appeal under section 1878(a)—not whether or how long after filing the appeal a provider may add issues to such an appeal. Indeed, the third sentence of section 1878(d) of the Act is reflected in § 405.1869 (''Scope of Board's decisionmaking authority''), instead of § 405.1841(a)(1) (''Time, place, form, and content or request for Board hearing''), since the original Board regulations.

Given our interpretation that section 1878 of the Act does not address whether or how long after filing an appeal a provider may add issues to the appeal, we believe our proposal to allow a 60-day period to add issues to such an appeal is an appropriate exercise of the Secretary's general rulemaking authority under sections 1102 and 1871 of the Act. As discussed previously, we believe this proposal strikes a reasonable accommodation between a provider's potential need to ensure the completeness of its original hearing request and the necessity of improving the Board's ability to reduce the case backlog.

Moreover, we believe the Board's powers under section 1878(d) of the Act do not apply to appeals from a revised NPR after a reopening. Instead, the Board's powers under section 1878(d) apply, for purposes of a single provider appeal, only to an appeal from an initial NPR that satisfies the jurisdictional requirements of section 1878(a) of the Act. We believe the Board's jurisdiction over post-reopening appeals is based on § 405.1889 of the reopening regulations, and not on section 1878(a) of the Act. See *French Hosp. Med. Ctr.* v. *Shalala,* 89 F.3d 1411, 1416–20 (9th Cir. 1996); *HCA Health Servs. of Oklahoma, Inc.* v. *Shalala,* 27 F.3d 614, 617–19 (D.C. Cir. 1994). Because section 1878(d) of the Act does not pertain to post-reopening appeals premised on § 405.1889 of the reopening regulations, our proposal to limit the period for adding issues to a post-reopening appeal does not seem inconsistent with the statute.

For the foregoing reasons, we propose to revise § 405.1811(c) and § 405.1835(c) to authorize a provider to add issues to an original request for an intermediary or Board hearing within 60 days after the expiration of the applicable 180-day period for making the original request. (See section II.V. of this preamble for a discussion of our proposal for the time in which to add issues following a reopening by an intermediary of a determination currently on appeal to the Board (proposed § 405.1885(c)(1)). Any

request to add issues would have to be in writing, satisfy the jurisdictional dissatisfaction requirements under proposed § 405.1811 (a)(1) or § 405.1835(a)(1), and meet the requirements governing the contents of a hearing request under proposed of § 405.1811(b) or § 405.1835(b), as applicable. Also, the provider would have to establish both that the original hearing request meets all applicable jurisdictional requirements, and that the original request combined with the matters identified for addition to that request satisfy the applicable amount in controversy requirement under proposed of § 405.1811(a)(2) or § 405.1835(a)(2). Moreover, we would continue our longstanding policies of prohibiting the addition of issues to a group appeal before the Board, as discussed in section II.H. of this preamble), and limiting the addition of issues in a single provider appeal from a revised NPR to those specific issues that are within the scope of the reopening and revised NPR.

We considered the alternative of eliminating altogether the opportunity to add issues to a single provider appeal. This alternative would be likely to enhance further the Board's capacity to reduce the case backlog. We believe, however, that a provider may reasonably need additional time to ensure its original hearing request is complete, and, if necessary, request addition of issues to the original request.

E. Provider Requests for Good Cause Extension of Time Period for Requesting Hearing (§ 405.1813 and § 405.1836)

[If you choose to comment on issues in this section, please include the caption ''Provider Request for Extension'' at the beginning of your comments.]

Current § 405.1813 and § 405.1841(b) authorize the intermediary hearing officer(s) and the Board, respectively, to extend ''for good cause shown'' the 180-day period for requesting a hearing. Under these regulations, a provider must file any request for a good cause extension within 3 years after the date of the original notice of intermediary determination.

We believe it is necessary to revise the regulations governing good cause extension requests for two reasons. First, there is a split among the Federal circuit courts of appeals on the threshold question of our authority to authorize the Board to extend the 180-day period for hearing requests under section 1878(a)(3) of the Act. The courts of appeals for the Eighth and Eleventh Circuits have held that the good cause extension request provisions in § 405.1841(b) are invalid because they are inconsistent with section 1878(a)(3) of the Act. (*St. Joseph's Hosp. of Kansas City* v. *Heckler,* 786 F.2d 848 (8th Cir. 1986); *Alacare Home Health Services, Inc.* v. *Sullivan,* 891 F.2d 850 (11th Cir. 1990).) By contrast, the Ninth Circuit has upheld our authority to authorize good cause extension requests before the Board, and concluded that a final agency decision on such a request is subject to judicial review under the Administrative Procedure Act, 5 U.S.C. 706(2)(A). *Western Med. Enters., Inc.* v. *Heckler,* 783 F.2d 1376 (9th Cir. 1986). Other courts, without addressing the issue of whether there is authority to allow an extension for good cause, have found that the courts do not have jurisdiction to review a finding by the Board or the Administrator that good cause did not exist in a particular case. See *Lenox Hill Hosp.* v. *Shalala,* 131 F. Supp. 2d 136 (D.D.C. 2000) and cases cited therein.

Second, we believe the case backlog at the Board also necessitates revision of the good cause extension request regulations. When the Board finds good cause to extend the 180-day period for requesting a hearing, another case is added to the backlog. Also, the lengthy 3-year period for requesting a good cause extension makes increases in the backlog more likely.

We propose to continue to authorize good cause extensions of the 180-day period for requesting a hearing. However, we also are proposing revisions to these regulations in response to the case law and the case backlog before the Board.

The split of authority among the Federal circuit courts of appeals regarding our authority to provide for good cause extensions led us to consider the alternative of eliminating these regulations altogether. Our proposal, to retain and revise the regulations instead, is based on several considerations. As discussed previously in the context of the regulations for adding issues to an original hearing request in section II.D.5. of this preamble, we believe the Board's jurisdiction over post-reopening appeals is based on § 405.1889 of the reopening regulations, and not on section 1878(a) of the Act. See *HCA Health Servs. of Oklahoma, Inc.* v. *Shalala,* 27 F.3d 614, 617–19 (D.C. Cir. 1994); *French Hosp. Med. Ctr.* v. *Shalala,* 89 F.3d 1411, 1416–20 (9th Cir. 1996). Thus, we see no statutory impediment to retaining good cause extension regulations for requests for a Board hearing based on a reopening and revised NPR.

As for a Board hearing request based on an initial NPR and section 1878(a) of the Act, we see some merit to both sides of the split of judicial authority as to our authority to provide for good cause extensions in such cases. Although our proposal to retain and revise these regulations is based primarily on policy considerations, we note that adoption of this proposal may result in additional court decisions and lead to a definitive resolution of whether the regulations are consistent with section 1878(a)(3) of the Act.

We believe it is appropriate to afford providers an additional period to submit hearing requests in limited circumstances. Specifically, in cases where a provider establishes it could not reasonably have been expected to submit a hearing request within the 180-day period due to extraordinary circumstances beyond its control (for example, natural or other catastrophe, fire, or strike), we believe it appropriate to authorize the Board and the intermediary hearing officer(s), as applicable, to extend the appeals period provided that the provider's good cause extension request is received by the Board within a reasonable time after the expiration of the 180-day period (but in no circumstances more than three years after the date of the intermediary determination). We emphasize that the circumstances justifying additional time to submit a hearing request truly would have to be extraordinary. Where such extraordinary circumstances would exist, what would be considered a ''reasonable'' additional period would depend on the particular situation and would be set according to the discretion of the Board or the intermediary hearing officer(s). The outer limit of three years after the date of the intermediary determination would be consistent with the time for seeking a reopening under proposed § 405.1885(b).

For the foregoing reasons, we propose to revise § 405.1813 and add a new § 405.1836 to authorize the intermediary hearing officer(s) and the Board, respectively, to extend the 180-day period for requesting an intermediary or Board hearing, as applicable. Proposed § 405.1813 and § 405.1836 include three principal revisions to the current regulations. First, our proposal to continue to authorize good cause extensions is limited under paragraph(a) of § 405.1813 and § 405.1836 to provider extension requests received by the Board or the intermediary hearing officer(s), as applicable, within a reasonable time after the expiration of the applicable 180-day period prescribed in proposed § 405.1811(a)(3) or § 405.1835(a)(3), as applicable.

Second, while the current regulations do not include specific guidance for

determining whether there is good cause for granting an extension request, we propose to add criteria for this purpose. Proposed § 405.1813(b) and § 405.1836(b) would provide that the intermediary hearing officer(s) and the Board, respectively, may find good cause to extend the time limit only if the provider demonstrates it could not reasonably have been expected to submit a hearing request within the 180-day period due to extraordinary circumstances beyond its control such as natural or other catastrophe, fire, or strike. Furthermore, § 405.1813(c)(1) and § 405.1836(c)(1) would prohibit the pertinent reviewing entity from granting a good cause extension request if the provider relies on a change (whether based on a court decision or otherwise) in the law, regulations, CMS Rulings, general CMS instructions, or CMS administrative ruling or policy as the basis for the extension request. We believe these proposals are a necessary and appropriate means to ensure that an additional period for submission of a hearing request is available only if the provider was prevented from submitting an appeal due to extraordinary circumstances beyond its control. We also believe the proposed prohibition of good cause extensions based on a change in the law will prevent the provider from appealing improperly a new issue—one it had not intended previously to appeal—after expiration of the 180-day period.

Third, we also are proposing revisions to delineate the consequences of a reviewing entity's decision on a provider's good cause extension request. A decision by an intermediary hearing officer(s) or the Board, to grant or deny a request for an extension for good cause, would be subject to review by a CMS reviewing official or the Administrator, as applicable. Because we view decisions on whether to grant an extension for good cause to be analogous to decisions on whether to reopen a previous determination or decision, we would state that a decision by the Board or the Administrator to not grant an extension for good cause would not be subject to judicial review under proposed § 405.1877(a)(3) or (a)(4).

In order to facilitate any further administrative review of such a decision, proposed § 405.1813(d) and § 405.1836(d) requires the pertinent reviewing entity to provide written notice of its decision to grant or deny a good cause extension request. Such notice must include an explanation of the reasons for the decision by the Board or the intermediary hearing officer(s), as applicable, and the facts underlying the decision.

Also, § 405.1813(e) and § 405.1836(e) includes proposals about the availability and timing of any review of such decisions. Specifically, § 405.1813(e) and § 405.1836(e) would provide that a decision by the Board or the intermediary hearing officer(s), as applicable, denying good cause and dismissing the appeal, is final and binding on the parties unless the decision is reviewed by the Administrator or a CMS hearing officer, respectively. Such a dismissal decision would be immediately reviewable. Proposed §§ 405.1813 and 405.1836(e) would further provide that if the Board or intermediary hearing officer(s) grants a good cause extension request, the decision would be non-final and not subject to immediate administrative or judicial review. Any non-final decision on an extension request would be reviewable solely during the course of review by the Administrator or a CMS hearing official, as applicable, of one of the decisions enumerated in § 405.1875(a)(2) or § 405.1834, respectively. We believe these proposals are an appropriate way to avoid piecemeal litigation, and are consistent with settled principles regarding the timing of administrative review.

Finally, proposed § 405.1836(e) would state that a determination by the Board or the Administrator that the provider did or did not demonstrate good cause for extending the time to request a hearing, is not subject to judicial review. We do not believe that it is necessary to propose a provision for § 405.1814 as that section would not provide for any judicial review of any decision by an intermediary hearing officer(s) or a CMS reviewing official.

F. Intermediary Hearing Officer Jurisdiction (§ 405.1814)

We propose to add a new § 405.1814 to impose certain requirements on intermediary hearing officers regarding making jurisdictional findings and to provide certain information on matters that are excluded from an intermediary hearing officer's jurisdiction. Proposed § 405.1814 would be similar to proposed § 405.1840, pertaining to Board jurisdiction, discussed below.

In proposed § 405.1814, we would require the intermediary hearing officer to make a preliminary determination of the scope of his or her jurisdiction, if any, over the matters at issue in the appeal, and notify the parties of his or her specific jurisdictional findings, before conducting any of the following proceedings: determining his or her authority to decide a legal question relevant to a matter at issue (see § 405.1829; permitting discovery (see § 405.1821); and conducting a hearing (see § 405.1819). Our proposal is designed to ensure the hearing officer's and the parties' focus on jurisdictional issues, for the purposes of making accurate decisions and to avoid committing needless time and resources in cases where jurisdiction is not present.

In issuing his or her decision, the intermediary hearing officer would be required to include a final jurisdictional finding for each specific matter at issue in the appeal. If the hearing officer determines that he or she lacks jurisdiction over every specific matter at issue in the appeal, he or she would issue a jurisdictional dismissal decision under § 405.1814(c)(2). Final jurisdictional findings and jurisdictional dismissal decisions by the hearing officer(s) would be subject to the CMS reviewing official procedure. Where a hearing officer does not dismiss an entire appeal, but instead finds that he or she lacks jurisdiction over a particular issue or issues, (or, conversely, finds that he or she has jurisdiction over a particular issue or issues) the hearing officer's jurisdictional ruling on such issue or issues would not be immediately reviewable, but rather would be reviewable upon the hearing officer's issuance of a hearing decision. Our proposal is intended to promote an efficient hearing and appeals process by not allowing for bifurcated appeals.

Finally, proposed § 405.1814 would specify that certain matters at issue are removed from the jurisdiction of the intermediary hearing officer, such as a finding in an intermediary determination that no payment be made by Medicare for costs incurred for items and services furnished to an individual because those items and services are excluded from coverage under section 1862 of the Act and our regulations. (Such a finding may be reviewed only in accordance with the applicable provisions of section 1869 of the Act, and of subpart G or H of part 405 of our regulations, pertaining to coverage appeals.) Another example of matters removed from the intermediary hearing officer's jurisdiction includes certain matters affecting payments to hospitals under the prospective payment system, as provided in § 405.1804.

G. CMS Reviewing Official Procedure (§ 405.1834)

Currently, our procedures for CMS review of intermediary hearings appear at § 2917 of the PRM. The procedures at § 2917 of the PRM were issued in response to the court's decision in *St. Louis University* v. *Blue Cross Hospital*

Service, 537 F.2d 283 (8th Cir. 1976). Because we believe that these procedures are of sufficient importance to warrant inclusion in the regulations, we propose to add a new § 405.1834 for that purpose.

In § 405.1834(a), we would specify the current rule that a provider, and only a provider, has the right to a review by the Administrator (acting by delegation to a CMS reviewing official) of an intermediary hearing officer decision. Unlike CMS Administrator review of a Board decision conducted in accordance with § 405.1875, if a provider requests review of an intermediary hearing officer decision and otherwise meets the requirements for review, the request must be granted. We also propose that the Administrator, through the CMS reviewing official, may take own motion review of an intermediary hearing officer decision, regardless of whether the decision is favorable to the provider. (Own motion review, as used here for review of intermediary hearing officer decisions and other reviewable actions, and also for Administrator review of Board decisions and other reviewable actions, is any review undertaken by the Administrator on his or her own initiative, including the situation where the Administrator takes review following a suggestion by a CMS component or other entity that review is appropriate.) We believe the rationale of *St. Louis University* is applicable to the situation where the intermediary hearing officer's decision is unfavorable to the provider as well as to the situation where the decision is favorable to the provider.

In proposed § 405.1834(b) we would specify the types of decisions that are and are not immediately reviewable. A final decision by the intermediary hearing officer denying a provider's good cause extension request; a final jurisdictional dismissal decision by the intermediary hearing officer (including any determination denying a provider's good cause extension request), and a final intermediary hearing decision would be immediately reviewable. Non-final actions taken by the intermediary hearing officer generally would not be immediately reviewable. For example, and in accordance with proposed § 405.1814(d), if an intermediary hearing officer finds that he or she has jurisdiction over one or more issues but not over another issue(s), the provider may seek review by a CMS reviewing official of the issue(s) for which the intermediary hearing officer found no jurisdiction, but may not seek such review until the intermediary hearing officer has issued an intermediary hearing decision. We would provide an exception, in the case of certain discovery or disclosure rulings, to the proposed provision that non-final actions may not be immediately appealed. We would *allow* immediate review, upon request of the provider or upon own motion of the Administrator, of any discovery or disclosure order (including an order made at the hearing) for which an objection based on privilege or other protection from disclosure was made. We would do so because any harm that may be caused by a discovery or disclosure order might not be rectified by a reversal of the order by the CMS reviewing official in the context of review of the intermediary hearing officer's final decision. An immediate review would be at the discretion of the CMS reviewing official. That is, although, a provider has the right to CMS reviewing official review (as discussed previously), whether the CMS reviewing official takes immediate review, where an objection based on privilege or other protection from disclosure was made, is discretionary. We discuss our proposal for immediate review of certain discovery and disclosure rulings further in section II.N., of this preamble.

In proposed § 405.1834(c) and (d), we would specify the time for a provider to request review, or for the CMS Administrator (through a CMS reviewing official) to take own motion review, of an intermediary hearing officer decision. In order for a provider request for review to be timely, the request must be received by CMS's Office of Hearings no later than 60 days after the date on which the provider received the intermediary hearing officer decision. The address of the Office of Hearings is: Suite CMS L, 2520 Lord Baltimore Drive, Baltimore, MD 21244–2670.

For provider requests for CMS reviewing official review of a discovery or disclosure order for which an objection based on privilege or other protection from disclosure was made, we would require the request to be made within 5 business days after the day the objection was made so as not to unduly disrupt the hearing process.

If the CMS Administrator wishes to take own motion review, through a CMS reviewing official, of an intermediary hearing officer decision, the CMS reviewing official must notify the parties and the intermediary of his or her intention to take own motion review no later than 60 days after the date the Office of the Hearings received the intermediary hearing officer decision. It is not necessary for the CMS reviewing official to issue his or her decision within such 60-day period.

In proposed § 405.1834(e), we would specify the procedures to be followed by a CMS reviewing official in reviewing an intermediary hearing officer's decision. A CMS reviewing official would be required to follow all applicable statutes, regulations and CMS Rulings, and would be required to afford great weight to other interpretive and procedural rules (such as those contained in the Provider Reimbursement Manual) and general statements of policy. The review by a CMS reviewing official ordinarily would be limited to the record of the proceedings before the intermediary hearing officer, but the CMS reviewing official could consider extra-record evidence if he or she determined under § 405.1823 that the evidence was improperly excluded from the record. The CMS reviewing official ordinarily would issue a decision based on the written record, but could decide to hold an oral hearing if he or she determines that an oral hearing is necessary. Upon completion of his or her review, the CMS reviewing official would issue a decision that affirms, reverses, modifies, or remands the intermediary hearing officer decision and would mail a copy of such decision to each party, to the intermediary and to CMS's Office of Hearings.

Proposed § 405.1834(f) would state the effect of a decision or a remand. Consistent with current procedures in section 2917 of the PRM, § 405.1834(f) would state that a CMS reviewing official decision that affirms, modifies or reverses the intermediary hearing officer's decision is final and binding on each party and on the intermediary, unless reopened, and is not subject to further appeal. A CMS reviewing official remand decision would not be a final decision and would have the effect of vacating the intermediary hearing officer's decision. A CMS reviewing official remand would require the intermediary hearing officer to take the actions specified in the remand order and to issue a new intermediary hearing officer decision.

H. Group Appeals (§ 405.1837)

[If you choose to comment on issues in this section, please include the caption ''Group Appeals'' at the beginning of your comments.]

Section 1878(b) of the Act and § 405.1837(a) of the regulations authorize a group of providers to appeal to the Board. (We note that group appeals are available for Board hearings, but not for intermediary hearings.) Each provider in a group appeal must satisfy individually the requirements for a single provider appeal under section

1878(a) of the Act and § 405.1835, except for the $10,000 amount in controversy requirement. Also, a group appeal is limited to those cases that involve a single common question of fact or interpretation of law, regulations, or CMS Rulings, in which the amount in controversy is, in the aggregate, $50,000 or more. Furthermore, the last sentence of section 1878(f)(1) of the Act, and § 405.1837(b), require providers under common ownership or control to bring any appeal, involving a legal or factual issue common to such providers and involving $50,000 or more in controversy in the aggregate, as a group appeal rather than allowing them to bring separate, single provider appeals.

We believe it is necessary to revise the group appeal provisions of § 405.1837 and propose appropriate revisions in order to ensure conformity with other proposed changes to the regulations. For example, we believe it is appropriate to propose revisions to § 405.1837 to conform the group appeal regulations to our proposed changes to the single provider appeal provisions of § 405.1835.

Another reason to propose revisions to § 405.1837 is that it is appropriate to clarify and update that regulation to reflect longstanding group appeal procedures. For example, our longstanding policy is that a group appeal may start as a Board hearing request for a group of providers or as a single provider appeal that later becomes a group appeal. Other longstanding policies limit each group appeal to only one common legal or factual issue, and prohibit the addition of new issues to a group appeal. We believe it is necessary and appropriate to propose revisions to § 405.1837 to reflect and update such longstanding policies for group appeals.

Under our proposal, § 405.1837(a) would be revised to clarify that each provider in a group appeal must satisfy individually the requirements for a single provider appeal (except for the $10,000 amount in controversy requirement). (We address the $50,000 amount in controversy requirement for group appeals separately for § 405.1839 in section II. I., for this preamble.)

Proposed § 405.1837(a)(1) would clarify that each provider must establish its dissatisfaction with Medicare payment for a specific item in accordance with our proposed revisions to § 405.1835(a)(1). This proposal would further clarify that each provider must demonstrate, for each disputed matter at issue, that it satisfied the 180-day deadline for appeal under our proposed revisions to § 405.1835(a)(3).

In proposed § 405.1837(a)(2), we would clarify our longstanding interpretation that a group appeal must be limited to one legal or factual issue that is common to each provider in the group. Section 1878(b) of the Act authorizes a group appeal if ''the matters in controversy involve a common question of fact or interpretation of law or regulation.'' We interpret the foregoing reference to ''a'' common legal or factual issue to mean that ''the matters in controversy'' (that is, the separate matters appealed by the different providers in the group) in one group appeal may involve only one common question of law or fact. Similarly, we construe the reference in the last sentence of section 1878(f)(1) of the Act to ''an issue common to such providers'' to mean that commonly owned or operated providers must file a separate group appeal for each common legal or factual question. Besides comporting with the statutory language, our interpretation has always been reflected in § 405.1837 and in our general policies and procedures for group appeals. (See, for example, Board's ''Group Appeal Instructions'' (July 1997)), reprinted in [CCH] Medicare and Medicaid Guide 7700.30 (each group appeal must ''contain one issue''; providers ''may not combine different issues''). See also PRRB Instructions, Part 1, Section B.I.d (March 2002).

We also propose to revise § 405.1837(b) to clarify the distinction between mandatory and optional uses of group appeal procedures, and to specify the different ways these two types of group appeals may be initiated. Proposed § 405.1837(b)(1) would require, consistent with section 1878(f)(1) of the Act and current § 405.1837(b), that any appeal brought by two or more commonly owned or controlled providers, involving a legal or factual question that is common to these providers, and involving $50,000 or more in controversy in the aggregate, be brought as a group appeal. Proposed § 405.1837(b)(2) would provide, consistent with section 1878(b) of the Act and current § 405.1837(a), that two or more providers not under common ownership or control may (but are not required to) bring a group appeal of a specific matter at issue that involves a common legal or factual question.

In proposed § 405.1837(b)(3), we would specify the different ways mandatory and optional group appeals may be initiated. We would require a provider subject to the mandatory group appeal requirements of section 1878(f)(1) of the Act and proposed § 405.1837(b)(1) to request, either alone or with other commonly owned or operated providers, a group appeal. We believe it is reasonable to require commonly owned or operated providers to initiate an appeal with a request for a hearing as a group because their common ownership or control should enable these providers to identify issues raising a common legal or factual question. By contrast, providers not under common ownership or control do not have a ready means to identify common issues with other providers. Thus, proposed § 405.1837(b)(3) would give providers not under common ownership or control an election between submitting at the outset a group hearing request, or starting with a single provider appeal and transferring common issues to a group appeal at a later time.

Also, we propose to add a new § 405.1837(c), which would specify the requirements for the contents of a request for a group appeal. Under proposed § 405.1837(c)(1), a group appeal request would have to be submitted in writing to the Board and include a demonstration that the request satisfies all requirements for a group appeal under proposed § 405.1837(a). Proposed § 405.1837(c)(2) would require each provider in the group appeal to demonstrate in its initial request its dissatisfaction with Medicare payment for each disputed item and compliance with the applicable 180-day appeal deadline, and to include a copy of each intermediary or Secretary determination under appeal and any other documentary evidence the provider believes necessary to demonstrate the dissatisfaction and timely filing requirements.

Under proposed § 405.1837(c)(3), the initial request for a group appeal must include a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal.

In proposed § 405.1837(c)(4), we would authorize an election as to when the group may demonstrate compliance with the $50,000 amount in controversy requirement. Our longstanding policy is to permit providers to submit a group appeal request before the group is fully formed. This policy reflects our recognition that it may not be possible for the group to satisfy the $50,000 amount in controversy requirement until other providers receive their respective NPRs and request a hearing as part of the same group appeal. Accordingly, proposed § 405.1837(c)(4) would give the group an election between establishing at the outset that all hearing requirements (for each

provider and for the whole group) are met, or showing initially that all requirements are satisfied except for the $50,000 amount in controversy requirement. Proposed paragraph (c)(4) would further require that the group appeal request include a statement representing that the providers believe the hearing request is jurisdictionally complete (and hence the Board can proceed to make jurisdictional findings) or the request is incomplete (and thus the Board should defer making jurisdictional findings).

We advance corresponding provisions in proposed new § 405.1837(d) regarding the Board's preliminary response to group appeal hearing requests. Apart from taking any ministerial steps deemed necessary upon receipt of such a request, the Board's principal response would be determined by the providers' representation under proposed § 405.1837(c)(4) as to whether the hearing request satisfies all requirements for a group appeal. For hearing requests described as jurisdictionally complete by the group, the Board would be required under § 405.1837(d) to make jurisdictional findings in accordance with new proposed § 405.1840 (see section II.J. of this preamble) before conducting any further proceedings. If the hearing request is described as jurisdictionally incomplete by the group, the Board would defer the requisite jurisdictional findings (and hence any further proceedings in the appeal) until the group represents that the hearing request is complete.

Proposed § 405.1837(e) clarifies the regulations to reflect and update our longstanding policies regarding the processing of group appeals pending full formation of the group and issuance of a Board decision. Proposed § 405.1837(e)(1) would authorize the filing of a group appeal hearing request before each member of the group has been identified or complied with the dissatisfaction and timely filing requirements, or before the group has satisfied the $50,000 amount in controversy requirement. Proceedings before the Board in any such partially formed group appeal would be determined by the remainder of proposed § 405.1837(e).

Under proposed § 405.1837(e)(2), the Board would not make the jurisdictional findings required under new proposed § 405.1840 until the group notifies the Board in writing that the group appeal is jurisdictionally complete. Proposed § 405.1837 (e)(3) authorizes the Board to take further steps necessary for consideration of the appeal only to the extent it finds jurisdiction over the specific matters at issue. In the event the Board finds jurisdiction before the group is fully formed, however, § 405.1837 (e)(3) would require the Board to make additional and updated jurisdictional findings after any ensuing changes in the composition of the group.

Proposed § 405.1837(e)(4) would authorize a provider to request from the Board permission to join a group appeal anytime before the Board issues one of the final decisions enumerated in proposed § 405.1875(a)(2). The Board would be required to grant any such request that is unopposed by any group member and received timely by the Board, and otherwise complies with § 405.1837. If the Board grants a request, the newly added provider would be bound by the Board's actions and decision in the appeal. If the Board denies the request, the provider could still submit a separate appeal on the same issue. The applicable 180-day period for filing a separate appeal (and the 60-day period for adding issues to any separate single provider appeal) would be suspended during the period from submission of the original hearing request through the Board's denial of the provider's request to join the group appeal. That is, following the Board's denial, the provider would have the same number of days to file an appeal or add issues that it had at the time it submitted the request to join the group appeal. We believe proposed of § 405.1837(e) reasonably reflects and updates our longstanding policies regarding group appeal processing pending full formation of the group and issuance of a Board decision.

In proposed § 405.1837(f), we would clarify that the specific matters at issue in a group appeal must be limited to one legal or factual question common to each provider in the group.

I. Amount in Controversy (§ 405.1839)

Section 405.1839 sets forth the requirements for determining the minimum amounts in controversy for intermediary and Board hearings ($1,000 for an intermediary hearing and $10,000 for a Board hearing.) We believe that certain aspects of the regulations need clarification to ensure the proper interpretation of the requirements by providers.

To clarify the method for determining the amount in controversy, we propose a series of minor revisions to § 405.1839. For both individual and group appeals, we would specify in proposed § 405.1839(a) and (b), respectively, that the amount in controversy is determined based only on those particular adjustments that the provider has challenged before the Board or the intermediary and includes the combined total of all issues raised by the provider that arise within the same cost year. Thus, a provider may aggregate issues within a cost year to meet the threshold amount. However, we would specify in proposed § 405.1839(a)(1) that a single provider may not aggregate issues across more than one cost year even if the issues involve the same payment adjustments being appealed in other cost years. We believe this proposed provision reflects the intent of section 1878(a)(1)(A)(i) of the Act, which specifies that a provider may obtain a Board hearing if it is dissatisfied with the intermediary's determination of the amount due the provider for the period covered by the provider's cost report. Therefore, a provider would have to meet the amount in controversy requirement for each cost year being appealed. In contrast, in proposed § 405.1839(b)(1) we would allow providers to aggregate issues across more than one cost year for purposes of meeting the amount in controversy requirement for group appeals. In *Cleveland Memorial Hospital, Inc.* v. *Califano*, 594 F.2d 993 (4th Cir. 1979), and *White Memorial Medical Center* v. *Schweiker*, 640 F.2d 1126 (9th Cir. 1981), the courts held that Congress's intent in enacting section 1878 of the Act was to permit providers in a group appeal to aggregate issues over more than one cost year, if necessary, to meet the amount in controversy requirement. We do not necessarily agree with the courts' view of Congressional intent and we note that the cases were decided prior to the Supreme Court's decision in *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), which held that courts must defer to an agency's interpretation of a statute that the agency is charged with administering, if the agency's interpretation is a permissible one. However, because we have conformed our policy to the courts' decisions since their issuance, and because no significant problems have been encountered with that policy, we see no reason to propose departing from it at the present time.

J. Board Jurisdiction (§ 405.1840)

We propose to add a new § 405.1840, which would be similar to proposed new § 405.1814, pertaining to intermediary hearing officer jurisdiction, as discussed at section II.F. of this preamble. In addition, we note that current § 405.1873 provides that the Board decides questions relating to its

jurisdiction and that the Board may not review intermediary determinations denying payment because the item or service is excluded from coverage under section 1862 of the Act. Because we believe it appropriate to state within § 405.1840 that the Board does not have jurisdiction to review an intermediary determination that an item or service is excluded under section 1862 of the Act, we propose to delete § 405.1873 and consolidate its provisions into new § 405.1840.

K. Expediting Judicial Review (§ 405.1842)

[If you choose to comment on issues in this section, please include the caption ''Expediting Judicial Review'' at the beginning of your comments.]

After the Board began conducting hearings under section 1878 of the Act, it became evident that in cases where providers challenged an intermediary's determination based on objections to the validity of the law, regulations or CMS rulings, a hearing before the Board would not resolve the dispute. Because these cases did not raise factual issues and because, under section 1878(e) of the Act, the Board is bound by the law and regulations, the Board was obliged to decide these cases against the provider. Although the provider could then seek judicial review in these cases (that is, file a complaint in a Federal district court), the provider effectively was required to participate in a futile hearing before the Board as a prerequisite to obtaining Federal court jurisdiction.

To remedy this situation, we published a proposed rule on February 14, 1980 (45 FR 9953) that sought to provide the Board with the authority to permit a provider to avoid the delay of a futile Board hearing and immediately seek to challenge the CMS policy in court. Before a final rule was published, section 1878(f)(1) of the Act was amended by section 955 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499) to allow providers to seek immediately judicial review of any action of the fiscal intermediary involving a question of the statute or regulations whenever the Board determined that it was without authority to decide the issue. Under the revised provisions of section 1878(f)(1), a provider can request that the Board make a determination of its authority to decide the issue before it. If the Board determines that it has jurisdiction over the issue but does not have the authority to decide the issue, the provider may obtain expedited judicial review. The legislative history indicates that the intent of revising section 1878(f)(1) was to eliminate undue delays resulting from the requirement that providers pursue time-consuming and unproductive administrative reviews before they could obtain judicial review of a Board determination. (H.R. Rep. No. 96–1167, at 394 (1980)).

Over the years, there has been some confusion about the types of cases to which expedited judicial review applies. For example, in appeals before the Board, providers have contended not only that intermediary audit adjustments are improper, but that the statute or regulation under which the intermediaries' review was conducted is invalid. The providers have argued that, because an aspect of the appeal concerns a challenge to a statute or regulation, expedited judicial review should be granted so that the legal matter can be contested in court while the audit adjustments are simultaneously being contested before the Board. The Board has denied these requests for expedited judicial review because it found that the issues before it involved the accuracy of the cost adjustments. In the Board's view, a provider's assertion that the audit procedure was in violation of a statute or regulation was not an issue for purposes of the judicial review provision but constituted a legal argument in support of the provider's position that the adjustments had to be reversed. The Board found that in the types of cases mentioned above, a hearing before it would not necessarily be futile because it often could decide the case and grant the relief sought by the provider based on other arguments presented.

We agree with the Board's position that, in situations in which a provider asserts that audit adjustments are improper and also argues that a statute, regulation, or CMS Ruling bearing on those adjustments is invalid, a Board hearing should be held before the matter proceeds to court. We believe that although an assertion that a statute, regulation, or Ruling is invalid is a matter that the Board cannot decide, the Board should accept the case and rule on those other issues relating to the same adjustments over which it has jurisdiction and does have authority to decide. Only in those cases in which the Board determines it has jurisdiction but does not have the authority to decide any of the issues raised with respect to a particular item by the provider, should it grant expedited judicial review as to those issues.

Accordingly, we propose the following revisions to § 405.1842.

To reflect more accurately the subject matter of this section, we would change the title from ''Expediting Board Proceedings'' to ''Expedited Judicial Review''. We would change all references in this section to reflect the revised title, including using the acronym ''EJR.'' We recognize that to say that the Board grants or does not grant expedited judicial review is not strictly accurate. The Board actually grants or denies the opportunity to seek expedited judicial review, because only the court can grant review by taking jurisdiction over the case. However, we believe ''expedited judicial review'' and ''EJR'' are suitable and commonly used terms to refer to proceedings at the administrative level.

In § 405.1842(a), we would clarify that providers may seek expedited judicial review when the Board decides, because it is bound by a relevant statute, regulation, or CMS Ruling, that, although it has jurisdiction, it does not have the authority to decide the issue. We consider jurisdiction to be a necessary prerequisite of the Board's ability to issue an EJR Decision. We would also clarify that the Administrator may review the Board's determination of whether it has jurisdiction over the matter(s) at issue, but may not review the Board's determination of whether it has the authority to decide such matter(s).

In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(1), we would emphasize that a Board finding that it has jurisdiction over the specific matter at issue is a prerequisite for its determination of its authority to decide the legal question, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR ''[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].'' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), consistent with the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision, that the 30-day time limit specified in section 1878(f)(1) of the Act for the Board to act on a provider's complete request does not begin to run until the Board has found jurisdiction on the specific matter at issue.

In § 405.1842(c), we would clarify the procedures for own motion consideration by the Board of whether to grant EJR. Upon finding that it has jurisdiction on a specific matter at issue, the Board would be authorized to consider, on its own motion, whether it lacks the authority to decide a legal question relevant to the matter at issue. The Board would be required to send written notice to each of the parties to the appeal so that they may respond with evidence or argument in favor of or against granting EJR.

In proposed § 405.1842(d) we would specify the procedures for provider requests for EJR, including the required contents of such requests.

In proposed § 405.1842(e), we specify the procedures for the Board to reply to provider requests for EJR and how we calculate the 30-day timeframe for issuing an EJR Decision following a provider request. In paragraph (e)(1) we would state that if the Board finds that it has jurisdiction over a matter for which the provider has requested EJR, the Board is then required to consider whether it lacks the authority to decide the legal question that is relevant to a matter. The Board would be required to issue an EJR decision for a matter no later than 30 days after the date of the Board's notice to the provider that the provider's request is complete. The condition that the 30-day timeframe does not begin to run until the Board has received a ''complete'' request from the provider is found in section 1878(f)(1) of the Act (a provider request for EJR shall be ''accompanied by such documents and materials as the Board shall require'' and ''the Board shall render [an EJR Decision] within thirty days after the Board receives the request and such accompanying documents and materials.'')

In proposed § 405.1842(e)(2) we would define a ''complete provider request'' as one that includes all of the information and documents found necessary for the Board to issue an EJR decision. In proposed § 405.1842(e)(3), we would specify what the Board must do when it has received a complete provider request or an incomplete provider request. Where the Board has received a complete provider request, it would be required to issue an EJR decision within 30 days of its receipt of the complete provider request. We would also specify that if the Board does not issue a timely EJR Decision (that is, no later than 30 days after the date of the notice issued under § 405.1842(e)(3)(i)), the provider has a right to file a complaint in Federal district court in order to obtain judicial review over the matter(s) at issue (see also proposed (§ 405.1842(g)(4)). Where the Board has received an incomplete provider request the Board would be required to issue a written notice to the provider describing the further information the Board requires.

In proposed § 405.1842(f), we would specify the criteria for the Board to apply for purposes of granting or denying EJR. If the Board has taken own motion consideration of whether to grant EJR, or if the provider has requested EJR, the Board would be required to grant EJR if it determines that it has jurisdiction over the specific matter at issue, and lacks the authority to decide the matter. The Board would be required to deny EJR if it determined it lacked jurisdiction over the specific matter at issue, or if it determined that it had the authority to decide the specific matter at issue, or if it did not have sufficient information to determine whether it had jurisdiction over, or had the authority to decide, the specific matter at issue. Subject to § 405.1842(h), the Board would be required to issue an EJR Decision (either granting or denying EJR) in any case in which it notified the provider that it was taking own motion consideration of whether to grant EJR under § 405.1842(c), or in which it notified the provider that its request for EJR was complete under § 405.1842(e). Under proposed § 405.1842(h) (discussed below), the Board would not be required or permitted to render an EJR Decision if the provider filed a lawsuit on the specific matter at issue for the same cost year at issue. The Board would also not be required or permitted to issue an EJR Decision following a provider request for EJR if the provider did not submit a complete request and did not perfect the request after being given the opportunity to do so under § 405.1842(e).

In proposed § 405.1842(g)(1), we would provide that, in accordance with proposed § 405.1875(a)(2)(iii), the Administrator may review, on his or her own motion, or at the request of a party, the Board's EJR Decision. The Administrator's review would be limited to the question of whether there is Board jurisdiction over the specific matter at issue. The Administrator would not be permitted to review the Board's determination of its authority to decide the legal question. To account for the possibility that a Board decision may grant EJR and the Administrator may find that the Board did not have jurisdiction over one or more of the specific matters at issue, the proposed rule would state that a Board decision granting or denying EJR is inoperative during the 60-day period for review by the Administrator. Proposed paragraph (g)(1) also would specify that a final Board EJR Decision under paragraph (f) of this section, and a final Administrator decision affirming, modifying, reversing or remanding a Board EJR Decision under § 405.1875(a)(2) and (e), may be reopened in accordance with §§ 405.1885 through 405.1889. Under proposed § 405.1842(g)(3), where a Board decision denies EJR for a specific matter at issue solely because it determines that it did not have jurisdiction over the matter, and the Administrator reverses the Board on the jurisdictional finding, and the Board determines on remand that it lacks the legal authority to decide the question, the provider would be able to file a complaint seeking EJR.

Proposed § 405.1842(h) would set forth the effect of final EJR Decisions by the Board and the Administrator, and the effect of lawsuits, on the Board's ability to conduct further proceedings on the appeal. Paragraph (h)(1) would provide that if the final decision of the Board grants EJR, the Board would be precluded from conducting any further proceedings on the legal question. The Board would be required to dismiss the specific matter at issue from the appeal unless the Board could fully decide the matter without a final resolution of the legal question for which EJR was granted. The Board would be required also to dismiss the entire appeal if there were no other matters at issue that were within the Board's jurisdiction and could be fully decided by the Board.

Proposed § 405.1842(h)(2) would specify the effect that a Board or Administrator decision denying EJR would have on the Board's ability to conduct further proceedings on the appeal. First, if the final decision of the Board were to deny EJR solely on the basis that the Board determines that it has the authority to decide the legal question relevant to the specific matter at issue, the Board would be required to conduct further proceedings on the specific legal question and issue a decision on the matter at issue in accordance with this subpart. (An exception to this rule would exist where the provider(s) files a lawsuit pertaining to the legal question; in that situation, the Board would be precluded from conducting any further proceedings on the legal question or the matter at issue before the lawsuit is finally resolved.) Second, if the Board or the Administrator were to deny EJR on the sole, or additional, basis that the Board lacks jurisdiction over the specific matter at issue, the Board would be required, as applicable, to dismiss the specific matter at issue from the appeal, or to dismiss the appeal entirely if there

were no other matters at issue that were within the Board's jurisdiction and could be fully decided by the Board. *Example 1:* Suppose a provider, after it received a revised NPR, filed an appeal and raised three issues, and sought EJR on the first issue. If the Board decided that the issue for which the provider sought EJR was not within the scope of the revised NPR, it would be required to dismiss that issue. If the Board found that the second and third issues were within the scope of the revised NPR, the appeal would continue (assuming there were no other jurisdictional problems with those issues), and the provider would not be able to seek Administrator (or judicial) review of the first issue until the Board issued a final decision on all the issues. (See proposed § 405.1840(d).) If, following a final decision by the Board on all the issues, the Administrator were to take review of the first issue and find that the Board did have jurisdiction, the Administrator would remand for the Board to determine whether it had the authority to decide the issue. If the Board were to decide on remand that it did not have the authority to decide the issue, then the Board would grant EJR on the issue. *Example 2:* Same as above except that the Administrator declines review or issues a timely decision affirming the Board's decision that it did not have jurisdiction on the first issue. In this case, the provider could appeal the Board's decision (if the Administrator declined review) or the Administrator's decision to court, and if the court were to reverse the Board's or Administrator's decision, the Administrator would remand the matter to the Board for a finding of whether the Board had the authority to decide the legal issue.

Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board—that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.

L. Parties to a Board Hearing (§ 405.1843)

Section 405.1843(a) of the regulations states that the parties to a Board hearing include the intermediary, the provider, and any related organization of the provider. This section also provides that CMS may be a party to the hearing only when it acts directly as an intermediary. Section 405.1843(b) provides that neither the Secretary nor CMS may be made a party to the hearing (except when CMS acts as an intermediary). With the disbandment of CMS's Office of Direct Reimbursement (formerly known as the Division of Direct Reimbursement), CMS no longer acts directly as an intermediary. Therefore, we propose to delete the obsolete references in § 405.1843(a) and (b) that provide that CMS may be a party to a hearing when it serves as an intermediary.

Although we are not a party to a Board hearing, our policies, actions and decisions are frequently central to a provider's reimbursement dispute before the Board. Moreover, in certain types of appeals, it is CMS, rather than the fiscal intermediary, that has made the determination being appealed by the provider.

Because our policies, actions and decisions may be at the center of many Board disputes, we believe the regulations should provide a mechanism by which CMS may be included in the hearings process, without having formal party status. Accordingly, we propose to add a new § 405.1843(c) to authorize intermediaries to designate a representative from CMS, who may be an attorney, to defend the intermediary's position in proceedings before the Board. We are modeling this portion of the regulations on the provisions authorizing the U.S. Department of Justice to allow an attorney (outside of the Department of Justice) to appear on its behalf in certain situations (see 28 U.S.C. 515). There may also be cases before the Board that have major policy implications that CMS would like to address without being designated as the representative of the intermediary. In these cases, proposed new § 405.1843(d)) would permit CMS to make written and timely filed *amicus curiae* submissions for the Board's consideration.

M. Quorum Requirements (§ 405.1845)

Section 405.1845(d) provides that a quorum is required for the rendering of Board decisions. Three Board members, at least one of whom is representative of providers of services, constitute a quorum. With the provider's approval, the Board Chairman may designate one or more Board members to conduct a hearing and prepare a recommended decision for adjudication by a quorum when a sufficient number of Board members are available.

As mentioned previously, the Board has an enormous case backlog. Approximately 10,000 hearing requests currently are awaiting disposition by the Board. In order to expedite the resolution of these cases and reduce this backlog, we propose several revisions to the quorum requirements under § 405.1845(d). First, because the presence of a quorum of Board members is not required at a hearing, we propose to clarify that more than one hearing may be held simultaneously. Under this proposed revision, the Board Chairman could designate one Board member to conduct a hearing. Under our proposal, it would not be necessary for the Board Chairman to obtain the approval of the provider or the intermediary before he or she could assign less than a quorum to conduct a hearing. We believe that the rights of the parties are not prejudiced by not requiring the Board to obtain the permission of the parties to have less than a quorum present at the hearing because no hearing decision would be rendered without the participation of a quorum of the Board members.

Second, we propose to eliminate the requirement that a recommended decision be prepared when less than a quorum has conducted the hearing. We believe that the preparation of a recommended decision is a time-consuming process that may be eliminated without affecting the fairness of the proceeding. A Board member who was not present at a hearing thus would be able to review the written record of the hearing and make a decision based upon that review. This proposed change is consistent with the Administrative Procedure Act, which provides at 5 U.S.C. 557(b) that an administrative officer charged with the decision making need not personally hear the testimony, but may rely instead on the written record.

We also propose that the Board may offer the parties the option to have the Board decide the case based on all the written evidence submitted by the parties. The parties would have to agree to waive their rights to an oral hearing as a condition for holding a ''hearing on the written record.''

N. Board Proceedings Prior to Hearing; Discovery in Board and Intermediary Hearing Officer Proceedings (§ 405.1853 and § 405.1821)

[If you choose to comment on issues in this section, please include the caption ''Board Proceedings Prior To Hearing'' at the beginning of your comments.]

We propose to make several revisions to § 405.1853. Proposed § 405.1853(a) would specify the present requirement that, prior to any Board hearing, the intermediary and provider must attempt

to resolve legal and factual issues, and following such attempt must send to the Board joint or separate written stipulations setting forth the specific issues that remain for Board resolution. We would remove the requirement that the intermediary ensure that all documentary evidence in support of each party's position is in the record. The intermediary does not have the capability or the responsibility for ensuring that all documentary evidence in support of the provider's position is made part of the record. We would continue the present requirement that the intermediary be required to place in the record a copy of all evidence that it considered in making its determination, and would add, that where the determination under appeal is a Secretary determination, the intermediary would be responsible for placing in the record all evidence considered by CMS in making the Secretary determination.

In proposed § 405.1853(b), we would address the timeframes for submitting position papers. Currently, § 405.1853(a) requires the provider and the intermediary to submit position papers, identifying issues that have been resolved between the intermediary and the provider and those that remain for Board resolution, to the Board no later than 60 days after the provider's hearing request. In many instances, the 60-day timeframe for submitting position papers has proved to be not a realistic or workable timeframe. We would remove the reference to the 60-day timeframe and instead provide in proposed § 405.1853(b) that the Board will set the deadlines for submitting position papers in each case as appropriate, and that the Board would have the authority to extend the deadline for good cause shown.

Additionally, we propose requiring that each position paper set forth the relevant facts and arguments concerning the Board's jurisdiction over each remaining matter at issue in the appeal, and that any supporting exhibits must accompany the position paper. These proposed requirements are intended to facilitate the Board's ability to make preliminary findings as to whether it has jurisdiction with respect to each specific matter at issue (see proposed § 405.1840(a)). All accompanying exhibits must be submitted in a form to be decided by the Board. Finally, proposed § 405.1840(b) would require that exhibits regarding the merits of the provider's appeal are to be submitted pursuant to the schedule set by the Board.

Proposed § 405.1853(c) and (d), would set forth requirements relating to ''initial'' and ''further'' status conferences. We would clarify that the Board may conduct status conferences for a wide variety of purposes, borrowing the criteria set forth in 42 CFR § 1005.6(b). Proposed § 405.1853(e) would make changes in discovery procedures for Board proceedings, and we would propose similar changes to § 405.1821 for proceedings before an intermediary hearing officer(s). In developing our proposals, we have attempted to balance competing considerations. On the one hand, and in accordance with the view that discovery generally is not available in record review cases before the courts, we believe that discovery should be limited, especially for non-parties. In this regard, we note that under our proposed revisions to § 405.1853(a) we would require that the intermediary, or CMS, as applicable, place in the record a copy of all evidence that the intermediary or CMS considered in making its determination, thus lessening any need for extra-record discovery. We are also concerned with the effect that broad discovery procedures may have on the Board's ability to schedule and hold hearings in an efficient manner. On the other hand, we recognize that reasonable discovery procedures can enhance the fairness of proceedings and the accuracy of decisions. Additionally, there may be circumstances where an entity that is not a party to a Board hearing, for example, CMS, is the only entity able to respond to provider discovery requests. A provider that seeks to obtain discovery materials from its servicing intermediary before a Board hearing is sometimes unable to do so because only a non-party has the requested information. We do not believe that it is fair to providers to deny them access to discovery material in these types of situations, and would therefore include non-parties within the scope of our proposed procedures.

Proposed § 405.1853(e)(1), and proposed § 405.1821(b)(1) would specify the basic requirements for discovery, including the requirement that the matter sought to be discovered must be relevant to the specific subject matter of the Board or intermediary hearing.

Proposed § 405.1853(e)(2) would specify that the method of discovery permitted would generally be limited to reasonable requests for the production of documents for inspection and copying, and a reasonable number of interrogatories, with depositions permitted in limited circumstances. A party would not be permitted to take an oral or written deposition of another party or a non-party, unless the proposed deponent agrees to the deposition, or the Board finds that the proposed deposition is necessary and appropriate under Federal Rules of Civil Procedure 26 and 32. (Under proposed paragraph (e)(1), the applicable provisions of the Federal Rules of Civil Procedure and Rules 401 (relevant evidence) and 501 (privileges) of the Federal Rules of Evidence would be used as guidance for all discovery permitted under this section or by Board order.) We would specifically state in paragraph (e)(2) that requests for admission, or any other form of discovery (other than requests for production of documents, interrogatories and depositions) are not permitted. Proposed § 405.1821(b)(2) would be similar, except that we would not permit depositions in proceedings before an intermediary hearing officer(s), as we do not believe the potential expense and inconvenience of a deposition is warranted given the limited amount in controversy in intermediary hearing officer hearings.

In § 405.1853(e)(3), we would revise the time limits for requesting discovery. Section 405.1853(b) provides that the Board must allow all timely requests for prehearing discovery, that is, requests made before the beginning of a hearing. Under this rule, a party is within its rights to file a discovery request as late as 1 day before a scheduled hearing, and the Board is bound to honor the request. We do not believe this is a reasonable requirement, especially in light of the current backlog of cases at the Board, and the substantial length of time between filing an appeal and the Board determination. We propose that a party's discovery request would be timely if the date of receipt of such a request by another party or non-party, as applicable, is no later than 90 days before the scheduled starting date of the Board hearing. A party would not be permitted to conduct discovery any later than 45 days before the scheduled starting date of the Board hearing. We would further provide that, upon request and upon a showing of good cause, the Board may extend the time for making a discovery request or may extend the time for performing discovery. Before ruling on an extension request, the Board would be required to give the other parties to the appeal (and any non-party subject to a discovery request) a reasonable period to respond to the extension request. The Board would be permitted to extend the time for requesting discovery or for conducting discovery only if the requesting party establishes that it was not dilatory or otherwise at fault in not meeting the original discovery deadline.

If the Board grants the extension request, it would be required to impose a new deadline and, if necessary, reschedule the hearing date so that all discovery ends no later than 45 days before the hearing. Proposed § 405.1821(a) would be similar for proceedings before an intermediary hearing officer(s).

In § 405.1853(e)(4) and § 405.1821(c), we propose to specify the rights of non-parties with respect to discovery requests. A non-party would have the same rights as a party in responding to a discovery request. These rights would include, but would not be limited to, the right to select and use any attorney or other representative, and to submit discovery responses, objections, motions, or other pertinent materials to the Board.

In § 405.1853(e)(5) and § 405.1821(c)(3), we propose a specific procedure for motions to compel and for protective orders. In order to conserve Board resources and promote an efficient hearing process, each party would be required to make a good faith effort to resolve or narrow any discovery dispute, including a dispute with a non-party. Any motion to compel discovery and any motion for a protective order, and any response thereto, would have to include a self-sworn declaration describing the movant's or respondent's efforts to resolve or narrow the discovery dispute.

In § 405.1853(e)(6), and in § 405.1821(d)(2), we would include a general rule, and an exception thereto, for the reviewability of Board or intermediary hearing officer(s) orders on discovery. Our general rule would be that any discovery or disclosure ruling issued by the hearing officer(s) or the Board is non-final and not subject to immediate review by the Administrator. Rather, such a ruling could be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2), or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3), as applicable. However, we also propose that where the Board or hearing officer(s) authorize discovery, or compel disclosure, of a matter for which a party or non-party made an objection based on privilege, or some other protection from disclosure, that portion of the discovery ruling would be reviewable immediately by the Administrator. If a party or non-party were required, over its objection, to disclose privileged materials or comply with an unduly burdensome request, the damage could not be undone by a reversal of the order by the Administrator in the context of review of the Board's or hearing officer(s)' final decision. For Administrator review of an order to be meaningful, it has to be available immediately to the party or non-party. We would provide for an automatic stay where the party or non-party, as applicable notifies the Board or intermediary hearing officer(s) of its intention to seek immediate review. The duration of the stay would be limited to no more than 15 days in the case of Board proceedings and to no more than 10 days in the case of intermediary hearing officer(s) proceedings. Under proposed §§ 405.1875(c)(1) and 405.1834(c)(3), a request for a review would have to be made within 5 business days after the party or non-party received notice of the Board's or intermediary hearing officer's ruling. If the Administrator grants a request for review or takes own motion review before the expiration of the stay, the stay would continue until the Administrator or CMS reviewing official renders a written decision, but if the Administrator does not grant or take review within the time allotted for the stay, the stay is lifted and the Board's or hearing officer(s)' ruling stands. We believe our proposal strikes an appropriate balance between the need to maintain the orderly flow of cases before the Board or the hearing officers, and a party's right to assert privilege or to be free from unduly burdensome requests.

O. Subpoenas (§ 405.1857)

We propose to revise and clarify our procedures for the Board issuance of subpoenas. In addition to specifying in some detail the procedures for requesting subpoenas and the required contents for subpoenas, we would make the subpoena process similar to the discovery process under § 405.1853 in several respects.

In proposed § 405.1857(a), we would impose time limits for requesting subpoenas that are similar to those we propose for discovery requests and orders. For subpoenas requested for purposes of discovery, a party would be allowed to request a subpoena no later than 90 days before the scheduled starting date of the Board hearing, and for subpoenas requested for purposes of an oral hearing, a request would have to be made at least 45 days before the scheduled starting date of the Board hearing. In addition, for purposes of a discovery subpoena or a hearing subpoena, the Board would not be allowed to issue a subpoena any later than 75 days, or 30 days, respectively, before the scheduled starting date of the Board hearing. For good cause, the Board would be allowed to extend the time for requesting a subpoena or for issuing a subpoena, provided that it gave certain procedural protections (including allowing any party, and CMS or any other non-party affected by the subpoena, the opportunity to comment on the proposed extension).

Consistent with our view that discovery should be available in appropriate circumstances from non-parties, we propose to specifically state in § 405.1857(a) that a subpoena may be issued to a non-party. Section 205(d) of the Act authorizes the Secretary to issue subpoenas requiring attendance, testimony, and production of evidence relevant to the matter under investigation. Section 1878(e) of the Act provides that the provisions of section 205(d) apply to the Board to the same extent that they apply to the Secretary. Section 405.1857 currently provides that the Board, either upon its own motion or upon the request of a party, may issue subpoenas ''when reasonably necessary for the full presentation of a case.'' There may be instances when the Board or a requesting party believes that a non-party should be subpoenaed to produce documents or testify. This section does not specify whether the Board's subpoena authority extends to non-parties. Therefore, we propose to revise § 405.1857 to clarify that a non-party may be subpoenaed by the Board. We believe this proposed revision is justifiable in view of the authority to issue subpoenas granted to the Board under section 1878(e) of the Act. We believe a non-party's rights would be adequately protected by extending to it the same rights a party would have in responding to a subpoena or subpoena request, see proposed § 405.1857(c)(3), and by allowing it to seek immediate Administrator review of a Board subpoena in some circumstances, (see proposed § 405.1857(d)(2)).

In proposed § 405.1857(d), we would propose the same general rule and exception for Administrator review of Board subpoenas that we propose for Administrator review of Board discovery rulings. That is, the rule would be that any subpoena issued by the Board would be non-final and not subject to immediate review, with the exception that immediate Administrator review could be had where the Board issued a subpoena for a matter for which a party or non-party made an objection based on privilege, or some other protection from disclosure. Our general rule and exception for Administrator review of Board subpoenas are based on the same considerations that led us to propose our general rule and exception

for Administrator review of Board discovery rulings.

In proposed § 405.1857(e), we would specify that only the Administrator has the authority to seek enforcement of a Board subpoena. We believe that because the Administrator is the Secretary's designee as the final administrative authority for appeals under section 1878 of the Act and has the authority to review Board issuances of subpoenas, it is appropriate that the Administrator have sole authority to seek enforcement of a subpoena. For example, it would make little sense to have the Board seek enforcement of a subpoena that the Administrator in the course of its review authority later determines to have been issued erroneously. Our proposal would also avoid any potential conflict whereby the Board would attempt to enforce a subpoena directed at CMS or the Secretary that the Administrator believes should not be enforced.

P. Record of Administrative Proceedings (§ 405.1865)

Section 405.1865, entitled ''Record of Board Hearing,'' requires that a ''complete'' record be made of the proceedings at the hearing before the Board, but does not specify what materials are to be made part of the record. It also does not explain how evidence or other material that is excluded by the Board or the Administrator is to be segregated in order to ensure that such excluded material is not inadvertently considered by the Administrator or by a court. We propose to amend § 405.1865 to address with specificity the required contents of the record on appeal and to explain how excluded material is to be treated. We would change the title from ''Record of Board Hearing'' to ''Record of administrative proceedings,'' to reflect that the recordkeeping requirements apply not only to Board review but to Administrator review as well. New paragraph (a) would specify that all evidence, argument and any other tangible material (admissible or inadmissible) received by the Board, as well as a transcript of the proceedings of any oral hearing before the Board, be made part of the record of the appeal. Paragraph (a) would also provide that a copy of such transcript must be made available to any party upon request. Proposed new § 405.1865(b) and (c) would make a distinction between the unappended record and an appendix to the record (although, as indicated above in the discussion of proposed paragraph (a), the term ''record'' is intended to encompass both the unappended and any appendix to the record). For purposes of the Board's decision, paragraph (b) would provide that the record would consist of such evidence and other materials accepted by the Board, as well as the transcript(s) of any oral hearing(s) before the Board. Any evidence ruled inadmissible by the Board, and any other material not considered by the Board in making its decision, must be, to the extent practicable, clearly identified and segregated in an appendix to the record for the purpose of any review by the Administrator and/or the judiciary.

For purposes of Administrator review, § 405.1865(c) would provide that the administrative record also includes all documents and any other tangible matter submitted to the Administrator by the parties to the appeal or by any non-party, in addition to all correspondence from the Administrator or the Office of the Attorney Advisor and all rulings, orders, and decisions by the Administrator. It would also specify that the provision in proposed § 405.1865(b), that excluded evidence and other non-considered matter should be segregated and placed in an appendix, also pertains to evidence or other matter submitted to the Administrator and found inadmissible or not considered by the Administrator. Finally, paragraph (c) would also provide that the Administrator has the authority to reverse the Board's determination regarding the admissibility of evidence or other matter. That is, the Administrator may exclude evidence or other matter that was admitted and considered by the Board if the Administrator determines that such evidence or other matter should not have been admitted and considered, and the Administrator may admit and consider evidence or other matter that was excluded and not considered by the Board if the Administrator determines that such evidence or other matter should have been admitted and considered by the Board.

Q. Board Actions in Response to Failure To Follow Board Rules (§ 405.1868)

Section 1878(e) of the Act provides the Board with ''full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section.'' In accordance with the broad latitude granted the Board under this provision, we propose to add a new § 405.1868 to specify that the Board has authority to take appropriate actions for failure to follow its established procedural requirements or for inappropriate conduct during hearings. In proposed § 405.1868(a), we would set forth this statutory language in the regulations to clarify the basis and breadth of the Board's authority for conducting hearings under section 1878 of the Act.

As discussed previously, the Board has an unusually large backlog of cases that results in substantial delays in hearings. The Board is not able to dispose of cases expeditiously, in part, because of deliberate tactics by the parties to the hearing to delay the proceedings. One of the major objectives of administrative dispute resolution is to provide a decision as quickly as possible, while still allowing each party a fair opportunity to present its case. Therefore, we are proposing to specify in the regulations how the Board would exercise its authority to take appropriate action in response to undue delay and/or a violation of its orders or rules. We propose to add a new § 405.1868(b) to provide that if the provider fails to meet any filing or procedural deadlines or other requirements established by the Board, the Board may dismiss the appeal, issue an order requiring the provider to show cause why the Board should not dismiss the appeal, or take other appropriate action. Also, proposed § 405.1868(c) would specify that if the intermediary fails to meet any filing or procedural deadlines or other requirements set by the Board, the Board may issue a decision based on the written record submitted to that point or take other appropriate action. We note that, as discussed above, the Board would also have discretion to grant an extension of time to a party that has failed to meet a filing or procedural deadline, but only if the party shows good cause for the delay in accordance with proposed § 405.1835(e).

R. Scope of Board's Authority in a Hearing Decision § 405.1869)

Section 1878(d) of the Act and § 405.1869 give the Board the power to affirm, modify, or reverse the intermediary's findings on each specific matter at issue in the intermediary determination for the cost reporting period under appeal, and to make additional revisions on specific matters regardless of whether the intermediary considered these matters in issuing the intermediary determination. We would clarify in § 405.1869(a) and (b) that the Board's power to make additional revisions in a hearing decision does not authorize the Board to consider or decide a specific matter at issue for which it lacks jurisdiction (see § 405.1840(b)) or which was not timely raised in the provider's hearing request.

We would also revise the title of § 405.1869 slightly.

S. Board Hearing Decision (§ 405.1871)

We propose to revise current § 405.1871 to provide more specificity as to the types of findings of fact and conclusions of law each Board decision must contain. We believe these revisions are appropriate as they will help ensure that the parties are fully informed as to the basis and reasoning of the Board's decision, and will also assist the Administrator or a court in determining whether or to what extent a Board decision should be upheld. Section 405.1871(a) states that the Board's decision must be based on evidence ''as may be obtained or received by the Board.'' We would revise this statement by clarifying that the Board's decision must be based on the admissible evidence from the Board hearing and such other admissible evidence and written argument or comments as may be received by the Board and included in the record. Consistent with our proposed revisions to § 405.1840 (Board jurisdiction) and § 405.1842 (expedited judicial review), we would require that the Board's decision contain findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue. (We propose to delete current § 405.1873, Board's jurisdiction, as no longer necessary.) We would also require the Board's decision to state whether the provider carried its burden of production of evidence and burden of persuasion, by establishing by a preponderance of the evidence that the provider is entitled to relief on the merits of the matter at issue. This requirement would ensure that the Board correctly allocated the burden of production and burden and proof on the provider, in accordance with our regulations at 42 CFR, part 413, CMS Ruling 79–60C, caselaw (see, *for example, Butler County Mem'l. Hosp.* v. *Heckler*, 780 F.2d 352 (3d Cir. 1985); *Fairfax Hosp. Ass'n* v. *Califano*, 585 F.2d 602 (4th Cir. 1978)), and general principles of administrative law. We would also require the Board's decision, with respect to any issue for which the policy expressed in a CMS instruction (other than a regulation or ruling) is dispositive but for which the Board would not affirm the intermediary's adjustment, to explain how it gave great weight to such instruction (as required by § 405.1867) but did not affirm the intermediary's adjustment. This requirement would ensure that the Board is giving proper weight to CMS instructions (other than regulations and Rulings, which are binding on the Board) and would allow a reviewing entity to discern the Board's specific disagreement with the policy expressed in the instruction.

In proposed § 405.1871(b), we would revise the statement in current paragraph (b), that the Board's decision is final and binding unless reviewed by the Administrator (or reopened and revised), to say that the Board's decision is final and binding unless the Administrator renders a decision reversing, modifying, affirming, or remanding the Board's decision (or unless the Board's decision is reopened and revised). The purpose of the proposed revision is to clarify that the act of taking review, by itself, that is, without a subsequent timely decision by the Administrator, will not provide a Board decision non-final and non-binding. However, consistent with proposed changes to §§ 405.1836(e)(2), 405.1842(g)(1), 405.1853(e)(6)(ii), 405.1857(d)(2), and 405.1868(f)(2), we also propose to clarify in paragraph (b) that the Board's decision is inoperative during the 60-day period of review by the Administrator.

T. Administrator Review (§ 405.1875)

[If you choose to comment on issues in this section, please include the caption ''Administrator Review'' at the beginning of your comments.]

We propose to clarify the existing procedures for obtaining Administrator review of a Board hearing decision, and to address what other types of Board decisions are subject to Administrator review, the timing of such review, and the procedures for obtaining such review.

We would revise § 405.1875(a) in several ways. We would revise the material in current paragraph (a)(2) relating to the role of the Office of the Attorney Advisor, and place it in the introductory language of paragraph (a). We would require all requests for Administrator review, as well as all written submissions to the Administrator specified in § 405.1875(c), whether they be from a party, or from an affected non-party such as CMS, to be sent to the Office of Attorney Advisor. We would also specify that the Office of Attorney Advisor must examine each Board decision and each review request and written submission, of which it becomes aware, in order to assist the Administrator in the exercise of his or her discretionary review authority. We say ''of which it becomes aware'' because we do not propose that the Board would be required to send all jurisdictional decisions and interlocutory orders and rulings to the Office of Attorney Advisor, as we do not believe it would be practicable to require the Board to do so, given the large number of such decisions and rulings. The Board does send a copy of all its decisions on the merits, including EJR decisions, to the Office of Attorney Advisor, and we would codify this practice in paragraph (a).

We would specify in proposed § 405.1875(a)(1) that the date of rendering of any Administrator decision must be no later than 60 days after the date of receipt by the provider of a reviewable Board decision or action. The date of rendering is the date the Administrator signs the decision, and not the date the decision is mailed or otherwise transmitted to the parties.

In proposed § 405.1875(a)(2), we would specify the types of final Board decisions that are subject to immediate review by the Administrator. The types of final decisions that the Board may issue, and which are subject to immediate review by the Administrator, would be specified in paragraph (a)(2) as: Board Hearing Decision (see § 405.1871); Board Dismissal Decision (see §§ 405.1836(e)(1) and (e)(2), § 405.1840(c)(2), §§ 405.1868(d)(1) and (2)); and Board Expedited Judicial Review Decision (see §§ 405.1842(h)). In addition to those decisions that would be specified as final in paragraph (a)(2), the Board may issue a decision or take some type of action from time to time that may have the characteristics of a final decision. Therefore, so as not to make the list of Board decisions specified in paragraph (a)(2) exhaustive, we propose that the Administrator would have the authority, in a given case, to deem a Board decision or action to be final and thus subject to immediate review. (For example, the Administrator might deem a Board remand order to be final if it ordered the intermediary or CMS to take certain action, which, if resulting in the reimbursement of costs or the granting of other relief, the Secretary would be unable to appeal. (see *Colon* v. *Sec'y of HHS*, 877 F.2d 148 (1st Cir. 1989); *Stone* v. *Heckler*, 722 F.2d 464 (9th Cir. 1983), and cases cited therein.)) We say ''in a given case'' because the fact that the Administrator would deem a particular action to be final in one case would not entitle a party to seek immediate review in another case, based on the party's belief that the action in the second case is similar to the action in the first case. Rather, upon request or on his or her own motion, the Administrator would have to specifically deem the Board's action in the second case to be final for purposes of immediate review.

Proposed § 405.1875(a)(3) would then specify that any Board decision or action not specified as final, or deemed to be final by the Administrator in a given case under paragraph (a)(2), would be non-final and not subject to immediate review, except for the following: a Board ruling authorizing discovery or disclosure of a matter for which an objection was made based on privilege or other protection from disclosure as case preparation or confidential material; and, a Board subpoena compelling disclosure of a matter for which an objection was made based on privilege or other protection from disclosure as case preparation or confidential material.

We believe the foregoing revisions would provide greater clarity as to what types of Board decisions may be immediately reviewable by the Administrator. In particular, we note that because the current regulations do not specify that the Board's assumption of jurisdiction in a case is a non-final action and not subject to immediate review by the Administrator, requests have been made by intermediary counsel to have the Administrator immediately rule that the Board incorrectly assumed jurisdiction. (By ''immediately,'' we mean prior to the issuance of a decision by the Board on the merits of the case.) Such requests have consumed time and resources of the Administrator despite the fact that it has been the Administrator's well-established practice to not immediately review the Board's taking of jurisdiction. By proposing that the Board's finding or assumption of jurisdiction is a non-final action and not subject to immediate review by the Administrator, we hope to avoid any confusion on this matter and to conserve needed resources. Conforming changes on this point would also be made to § 405.1840(d).

We also believe that the two proposed exceptions to the proposed policy that non-final orders would not be immediately reviewable are necessary and appropriate. Our reasons for the exceptions are also grounded in the recognition that certain non-final orders have a practical finality to them. That is, a Board order authorizing discovery or disclosure of, or a Board subpoena compelling disclosure of, a matter for which an objection was made based on privilege or other protection from disclosure as case preparation or confidential material, is for all intents and purposes final unless it is immediately reviewable, for once the disclosure is made the effects of the disclosures cannot be reversed.

In proposed § 405.1875(b), we would specify an illustrative list of criteria the Administrator will use to determine whether he or she will review a reviewable Board decision or reviewable Board non-final order. (We would revise the material in current paragraph (b), relating to the time in which to seek review of a Board decision, and place it in paragraph (c), as discussed below.) The criteria we would specify include, with slight expansion, the criteria that appears in current paragraph (c). We would specify that the Administrator will consider criteria ''such as'' the criteria listed, in order to emphasize that the list is not exclusive, and thus is not a limit on the Administrator's discretionary review authority. (The current language ''the Administrator will normally consider'' is also intended to convey that the list is not exclusive.) We would reserve the right for the Administrator to exercise discretionary review authority for reasons other than those listed, although we have attempted to anticipate all the reasons for which the Administrator would take review and include those reasons in the proposed list. We wish to point out three proposed changes. First, we would delete the current criterion of whether the Board's decision is supported by substantial evidence. Substantial evidence is less than a preponderance, and we believe it is appropriate for the Administrator to exercise discretionary review authority where the Administrator concludes that the Board's decision is incorrect, even if the Board's decision is supported by substantial evidence. Second, we would include as a criterion whether the Board's hearing decision met the requirements of section 405.1871(a). The proposed change would reflect that under proposed § 405.1871(a), the Board's decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue, and whether the provider carried its burden of production of evidence and burden of persuasion, and must include appropriate citations to authority. We believe it is appropriate for the Administrator to review any Board hearing decision that does not meet these requirements. Third, we would include as a criterion whether the Board erred in refusing to admit certain evidence or in not considering other submitted matter, or erred in admitting certain evidence or considering other submitted matter (see § 405.1855 and proposed § 405.1865(b)).

We would revise the procedures for Administrator review in current § 405.1875(c) and (d), and set them forth in proposed paragraph (c). In proposed paragraph (c)(1), we would specify that a party or CMS may request review of any reviewable decision or reviewable non-final order (as specified in (a)(2) and (a)(3), respectively), but a non-party other than CMS may request review only of a Board discovery order or subpoena to which an objection was made based on privilege or other protection from disclosure as case preparation or confidential material. We would also allow a party or CMS to respond to any request for review. A request for review, or a response to a request, would have to be in writing, identify the specific issues for which review is requested, and explain why review is or is not appropriate, under the criteria set forth in paragraph (b) or for some other reason. In order to be timely, any review request would have to be received by the Office of the Attorney Advisor no later than 15 days after the date the party or non-party making the request received the Board's decision or other reviewable action. We would require a copy of any review request (or response to the request) to be mailed promptly to the Office of the Attorney Advisor, to each party to the appeal, to CMS, and to any non-party other than CMS that is affected.

In proposed § 405.1875(c)(2), we would provide that, whenever the Administrator decides to review a Board decision or other matter, the Administrator issue a written notice to the parties, to CMS, and to any other affected non-party that a Board's decision or other matter will be reviewed, and indicate in the notice the specific issues that will be considered. We would also restate in proposed paragraph (c)(2) that which appears in current paragraph (d)(2), namely, that the Administrator may decline to review a Board decision or other matter, or any issue in a decision or matter, even if a proper request for review was submitted. We would specify that where the Administrator declines to review a Board decision, the Administrator will notify the parties, CMS, and any other affected non-party.

In proposed § 405.1875(c)(3), we would propose minor changes to the process (which currently appears at paragraph (e)) for making written comments to the Administrator following notice that the Administrator has decided to take review. Consistent with other changes and clarifications to § 405.1875 discussed above, we would specify that: (1) CMS or any other affected non-party that has properly requested review may submit comments; (2) comments may be

submitted in response to any Administrator notice of intention to review a Board decision or other reviewable action; (3) all comments must be filed with the Office of the Attorney Advisor. We would also specify that the date of receipt by the Office of the Attorney Advisor of any comments must be no later than 15 days after the date the party, CMS or other affected non-party submitting comments received notice of the Administrator's intention to take review.

Proposed § 405.1875(d) would contain what currently appears in paragraph (f) for the prohibition on *ex parte* communications, with one minor change. Because CMS or another affected non-party would have the right to seek Administrator review of certain matters under proposed paragraph (c)(1), and would have the right to make written submissions to the Administrator under proposed paragraph (c)(3), it is necessary to specify that the rules on *ex parte* communications would apply to affected non-parties.

In proposed § 405.1875(e), we would update and revise the procedures for issuing an Administrator decision that currently appear in paragraph (g). In proposed paragraph (e)(1)(i), we would specify that, for review of a Board decision described in section 1875(a)(2), an Administrator decision will affirm, reverse, modify, or vacate and remand the Board's decision. In proposed paragraph (e)(1)(ii), we would state that with respect to review of one of the reviewable non-final orders listed in section 1875(a)(3), an Administrator decision will affirm, reverse, modify or remand the Board's order, and will remand the case to the Board for further proceedings. Thus, the distinction between an Administrator decision that follows review of a Board decision, and an Administrator decision that follows review of a reviewable Board non-final order, is that in the latter situation the Administrator decision will always return the case to the Board for further proceedings.

In proposed paragraph (e)(2) we would specify that the date of rendering of any decision of the Administrator under (e)(1)(i) or (e)(l)(ii) must be no later than 60 days after the date of the provider's receipt of the Board's decision or reviewable non-final order. We would also require that a copy of the Administrator's decision be sent to any affected non-party.

In proposed paragraph (e)(3) we would specify the exclusive list of factual and legal materials on which the Administrator may base his or her decision. The list of materials is similar to that specified in current paragraph (g)(3), except that, by stating that the Administrator may base his or her decision on ''[t]he administrative record for the case (see § 405.1865),'' we mean to include materials that the Board excluded but which the Administrator determines should have been admitted, and we mean to exclude materials that the Board admitted but which the Administrator determines should have been excluded. The language in current § 405.1875 (g)(3)(ii), relating to comments submitted to the Administrator, has been deleted, because comments are contained within the proposed administrative record category, as the administrative record would be defined in § 405.1865 to include all written materials submitted to, and accepted by, the Administrator. For the sake of consistency, we would also make the exclusive list of factual and legal materials on which the Administrator may base his or her decision applicable to decisions by the Administrator to remand. This would be a change from current paragraph (g)(3), which specifies ''[a]ny decision other than to remand.''

In proposed paragraph (e)(4), we would specify the effect of a timely decision by the Administrator. We believe it is appropriate to do so in order to notify the parties of their rights and responsibilities. We would specify that a timely Administrator decision that affirms, reverses, or modifies a final Board decision (that is, a Board decision specified in § 405.1875(a)(2)) is final and binding on each party to the appeal, and we would cross-reference § 405.1877(a)(4). Section 405.1877(a)(4) would specify that where the Administrator affirms, modifies or reverses a Board decision, the Administrator's decision—and only the Administrator's decision—is subject to judicial review. In addition, we would specify in proposed paragraph (e)(4) that if such an Administrator decision is not appealed to a court, the intermediary has the responsibility of implementing the decision in accordance with proposed § 405.1803(d). We would also specify that an Administrator decision may be reopened by the Administrator in accordance with our regulations on reopening (§ 405.1885 through 405.1889). In addition to stating the above effects of a final Administrator decision, we would specify in paragraph (e)(4) that a decision by the Administrator to remand a matter to the Board for further proceedings is not a final decision for purposes of judicial review, and does not invoke the effectuation responsibilities of § 405.1803(d).

Finally, in proposed § 405.1875(f), we would revise the rules and procedures that currently appear in paragraph (h) on Administrator remand orders. In proposed paragraph (f)(1)(i) we would specify that an Administrator remand order of a Board final decision (see section 1875(a)(2)) has the effect of vacating that decision and requiring further proceedings in accordance with the Administrator remand order, and in proposed paragraph (f)(1)(ii) we would specify that an Administrator affirmance, reversal, modification, or remand of a reviewable Board non-final order (see § 405.1875(a)(3)) has the effect of requiring further proceedings in accordance with the Administrator order. These statements in paragraphs (f)(1)(i) and (f)(1)(i) would also appear in paragraphs (e)(1)(i) and (e)(1)(ii).

Proposed paragraph (f)(2) would contain the text that currently appears in § 405.1875(h)(2), with some clarifying changes. In proposed paragraphs (f)(3)(and (f)(4), we would make minor revisions to the text that currently appears at (h)(3) and (h)(4). Current paragraph (h)(3) specify that the Board will take the action ''requested'' in the Administrator's remand order, and we would clarify this language to state that the Board is required to take the actions required in the Administrator remand order. Also, where current paragraph (h)(3) specifies that the Board will issue a new ''decision'' in response to the Administrator remand order, we would specify that the Board is required to ''issue a new decision pursuant to paragraph (f)(1)(i) of this section, or an initial decision or a further remand order, discovery ruling, or subpoena, as applicable, under paragraph (f)(1)(ii).'' The purpose of the proposed language is to recognize that the subject of the Administrator's review and ensuing remand order may have been a final Board decision as described in proposed paragraph (a)(2) of § 405.1875 (in which case a ''new'' decision would be required from the Board), or it may have been a reviewable non-final order as described in proposed § 405.1875(a)(3) (in which case the Board would be required to issue an ''initial'' decision, or no decision at all, but rather a further remand order, discovery ruling, or subpoena ruling). Similarly, current paragraph (h)(4) specifies that the ''new decision'' issued by the Board in response to the Administrator remand will become final unless affirmed, reversed, modified, or remanded again by the Administrator. Proposed paragraph (f)(4) would take into account that, in response to the Administrator

remand order, the Board may be required to issue a new final decision or an initial decision (which would be the final decision of the Secretary unless affirmed, reversed, modified, or remanded by the Administrator), or the Board may be required to issue a further remand order, discovery ruling, or subpoena ruling (which would not be the final decision of the Secretary regardless of whether the Administrator took review of the further remand order, discovery ruling, or subpoena ruling).

In proposed paragraph (f)(5), we would specify that the Administrator has the authority to remand a matter not only to the Board, but also to any component of HHS or CMS, or to an intermediary, under appropriate circumstances (including, but not limited to the purpose of implementing a court's order). We recognize there is a split of authority on the issue of whether the Administrator has remand authority, but we believe the better view is espoused in *Gulf Coast Home Health Services, Inc.* v. *Califano,* 1978 U.S. Dist. LEXIS 15069 (D.D.C. 1978).

U. Judicial Review (§ 405.1877)

[If you choose to comment on issues in this section, please include the caption ''Judicial Review'' at the beginning of your comments.]

We propose to clarify the existing procedures for obtaining judicial review of a Board or Administrator decision, and to specify how court remand orders will be processed and implemented. Current § 405.1877(a) specifies that a ''final decision of the Board'' is subject to judicial review (and that a Board's decision is not final if the Administrator timely affirms, modifies or reverses it), but does not otherwise define ''final decision of the Board.'' We would revise paragraph (a), consistent with our proposed revisions to § 405.1875, to specify that a Board decision is final if it is one of the decisions specified in proposed § 405.1875(a)(2)(i) through (iv), and has not been timely reversed, affirmed, modified, or remanded by the Administrator. The types of decisions specified in proposed § 405.1875(a)(2)(i) through (iv) are: Board Hearing Decision (see § 405.1871); Board Dismissal Decision (see § 405.1836(e)(1) and (2), § 405.1840(c)(2) and (3), § 405.1868(d)(1) and (2)); Board Expedited Judicial Review Decision (see § 405.1842(h)); and any other decision deemed final by the Administrator in a particular case. Also, because we occasionally receive civil complaints filed against the Administrator of CMS or CMS itself, or an intermediary, we would inform that the only proper defendant in an action brought under section 1878(f)(1) of the Act is the Secretary. Finally, in response to a question we received, we would clarify that where a provider is dissatisfied with a final and otherwise judicially reviewable decision of the Board, it is not necessary that the provider ask the Administrator to review the decision under § 405.1875. If the provider does not ask the Administrator to review a final Board decision, and the Administrator does not review it, the provider may nonetheless seek judicial review of the Board decision. (Of course, if the Administrator were to review the Board decision and issue an Administrator decision, the Administrator decision would be the only decision subject to review.) Although we believe this principle can be gleaned from the absence of any requirement in our current regulations to seek Administrator review before seeking judicial review of a final Board decision that has not been affirmed, modified, reversed or remanded by the Administrator, we believe it is worthwhile to add specific language to proposed paragraph (a)(3) on this point.

In proposed § 405.1877(b) we would clarify the language in existing paragraphs (b) and (c) as to the time for seeking judicial review in the following three situations: (1) The Administrator declines review; (2) the Administrator accepts review and timely reverses, affirms, or modifies the Board decision; and (3) the Administrator accepts review but does not timely render a decision. Although it has always been our policy that Administrator remand orders are non-final and not subject to judicial review, and although current paragraph (a) implies as much by stating that a decision by the Administrator reversing, affirming, or modifying a Board decision is subject to judicial review, we would specify explicitly in proposed paragraph (b)(3) that an Administrator remand of a Board decision is not subject to judicial review. We would also clarify existing policy in proposed paragraph (b)(3) by stating that an Administrator remand of a Board decision vacates that Board decision and that the vacated Board decision is not subject to judicial review.

In proposed paragraph (c)(1), we would specify the limitation expressed in section 1878(g)(1) of the Act, that an intermediary's finding that expenses incurred for items and services by a provider to an individual are not payable because those items or services are excluded from coverage under section 1862 of the Act, is not reviewable by the Board and is not subject to judicial review under section 1878(f)(1) of the Act. We would specify that the finding is subject to administrative review under our regulations at 42 CFR, subparts G and H, of Part 405, and subpart A of Part 478, as applicable, and is subject to judicial review in accordance with the applicable provisions of sections 1155, 1869 and 1879(d) of the Act. In proposed paragraph (c)(2), we would restate, with minor modification, the language in current paragraph (d), that certain matters affecting payment to hospitals under the prospective payment system are not subject to administrative or judicial review, as provided in section 1886(d)(7) of the Act, and § 405.1804 and proposed § 405.1840(b)(2) of our regulations.

In proposed paragraph (d), we would clarify language in current paragraph (e), relating to group appeals. Specifically, we would specify that any providers that wish to seek judicial review of a final Board or Administrator decision on a group appeal brought under § 405.1837, must do so as a group for the specific matter at issue and common factual or legal issue that was addressed in the final Board or Administrator decision.

In proposed § 405.1877(e)(1) and (e)(2), we would restate, with minor language changes, the provisions of current paragraph (f) for the venue requirements for single and group court appeals, respectively. A civil action seeking judicial review of a single provider appeal must be brought in the District Court of the United States in which the provider is located, or in the United States District Court for the District of Columbia. A civil action seeking judicial review of a group appeal must be brought in the District Court of the United States in which the greatest number of providers participating in both the group appeal and the civil action are located, or in the United States District Court for the District of Columbia.

Current § 405.1877(g), pertaining to service of process, would be redesignated as paragraph (f).

In proposed paragraph (g)(1), we would provide that, subject to proposed paragraph (g)(3), a court's remand order will be deemed to be directed to the Administrator for processing, regardless of whether the order refers to the Administrator, the Secretary or some component of the Department of HHS, the Board or the intermediary. We believe that such a rule is appropriate because the Secretary is the real party in interest in any civil action seeking judicial review of a final decision by the Administrator or the Board, and the Secretary has delegated responsibility to

the Administrator to review decisions of the Board and to issue final decisions on behalf of the Secretary. In proposed paragraph (g)(2), we would specify the procedures for the Administrator to follow in processing a court remand order. Upon receipt of a court remand order, the Administrator would prepare an appropriate remand order and, where applicable, file the order in any Board appeal at issue in the civil action. However, we would also provide, in paragraph (g)(3), that the above rule does not apply if its application would be inconsistent with the court's remand order or any other order of a court regarding the civil action.

V. Reopening Procedures (§§ 405.1885 Through 405.1889)

[If you choose to comment on issues in this section, please include the caption ''Reopening Procedures'' at the beginning of your comments.]

Regulations in Subpart R of Part 405 provide for a reopening and revision procedure. A reopening and revision renders non-final and non-binding a determination, that, left undisturbed, would otherwise have been final and binding. A reopening procedure is neither specifically authorized, nor required, by statute. Rather, reopening is authorized only by our regulations, based on the Secretary's general rulemaking authority in sections 1102(a) and 1871(a) of the Act. (See *HCA Health Servs. of Oklahoma, Inc.* v.*Shalala,* 27 F.3d 614, 618 (D.C. Cir. 1994). See also *Your Home Visiting Nurse Servs., Inc.* v. *Shalala,* 525 U.S. 449, 454 (1999)).

We propose to clarify our procedures on reopening and revising final determinations. Previously, not all of our policies were set forth explicitly in regulations, and there was litigation on specific issues. Our proposals are an attempt to provide as clear a statement of our policies as possible. We also note that a few clarifications to the reopening rules were recently made, in the final rule published at 67 FR 49982 (August 1, 2002). That rule first clarified that an intermediary's discretion under section 405.1885(a) to reopen or not reopen a particular matter is limited by an explicit directive from CMS pertaining to that matter. That is, CMS retains the ultimate authority as to whether an intermediary may or may not reopen a matter, and one should not infer that CMS has directed an intermediary to reopen a matter, in the absence of a explicit direction from CMS to the intermediary. The August 1, 2002 rule also clarified that a change in legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or intermediary hearing officer decision. Finally, in response to a comment on the proposed rule, the August 1, 2002 final rule clarified that CMS may direct an intermediary to reopen a particular intermediary determination or decision in order to implement a final agency decision, a final and non-appealable court judgment, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

Our proposed changes to the reopening rules, set forth below, would incorporate the clarifications made by the August 1, 2002 final rule.

1. Reopening an Intermediary or Secretary Determination or Reviewing Entity Decision (§ 405.1885)

We propose to revise and make several changes to § 405.1885. In proposed § 405.1885(a), we would set forth an overview of the reopening process. We would specify that a Secretary or intermediary determination or a decision by a reviewing entity (that is, an intermediary hearing officer(s), a CMS reviewing official, the Board or the Administrator, see § 405.1801(a)) may be reopened either through own motion by the intermediary or the applicable reviewing entity, or by granting a provider's request to reopen. (Our current regulations do not address reopening of Secretary determinations (which are rendered by CMS), such as a determination to grant or deny a provider's request for an adjustment to its rate-of-increase ceiling under § 413.40(e). Nor do they address reopening of decisions by CMS reviewing officials.) We would also reiterate in paragraph(a) one of the points made in the August 1, 2002 final rule, namely, that CMS has the final say as to whether an intermediary or intermediary hearing officer(s) may or may not reopen an intermediary determination or intermediary hearing decision. We would provide that where CMS directs an intermediary or intermediary hearing officer(s) to reopen an intermediary determination or decision, the resulting reopening is considered an own motion reopening. (Proposed § 405.1885(b) would set forth specific time limits for reopenings by request and for own motion reopenings.) Finally, we would provide that a decision whether or not to reopen a determination or decision is not subject to further administrative review and inform that it is not subject to judicial review. We have always regarded determinations to reopen or not to reopen to be within the sole discretion of the intermediary or the reviewing entity, as applicable. In *Your Home Visiting Nurse Services, Inc.* v. *Shalala*, 525 U.S. 449, 454 (1999), the Supreme Court affirmed our policy that a determination by the intermediary not to reopen was not subject to administrative or judicial review.

In proposed § 405.1885(b), we would revise and clarify the time limits for reopening. In proposed paragraph (b)(1), we would clarify that in order for CMS, the intermediary, or a reviewing entity to reopen timely on its own motion, the notice of reopening must be mailed no later than 3 years after the date of the original determination or decision that is the subject of the reopening. In proposed paragraph (b)(2), we would specify the time in which a request to reopen must be made. Current § 405.1885(a) specifies that a request to reopen ''must be made within 3 years of the date of the notice'' of the determination or decision. We propose to clarify this language by stating that a provider request to reopen must be *received* by the intermediary or reviewing entity, as applicable, no later than 3 years after the date of the rendering of the original determination or decision by the intermediary or reviewing entity. The 3-year standard applies to receipt of the request for reopening, not to the issuance of a reopening notice. When the request for reopening is received late in the 3-year period, the issuance of a reopening notice does not have to occur before the expiration of 3 years. The intermediary may take a reasonable amount of time to consider the request and seek additional information, and may then issue the notice of reopening. We believe this proposed change will avoid any question as to whether a request for reopening was timely. We would also clarify in paragraph (b)(2) that a request for reopening, does not, by itself, alter the time for seeking administrative or judicial review of a determination or decision. Example: A provider receives a notice of amount of program reimbursement on January 2. Under our regulations the provider has 180 days from January 2 to seek a Board hearing (unless the time is extended for good cause). Under our proposal, if the provider requested a reopening on March 2, the request, by itself, would not extend the time for seeking a Board hearing, and the time to request a Board hearing would continue to be 180 days after January 2. (We discuss below our proposed clarifications to § 405.1887 concerning the effects a notice of reopening and a notice after reopening

have on the time to appeal a determination or decision.)

Proposed paragraph (b)(3) would combine the substance of language that currently appears in § 405.1885(a) and (d), namely that an intermediary determination or a decision by the reviewing entity may not be reopened after the 3-year period specified in proposed (b)(1) and (b)(2), except where the determination or decision was procured by fraud or similar fault, in which case reopening may be made at any time.

In proposed § 405.1885(c) we would restate our current rules on which component or entity has the authority to reopen a prior determination or decision. With one exception, authority or ''jurisdiction'' to reopen would be the exclusive province of the component or entity that rendered the determination or decision that is the subject of the reopening. Thus, jurisdiction for reopening a Secretary determination, CMS reviewing official decision, Board decision, and Administrator decision would lie exclusively with CMS, the CMS reviewing official, the Board, and the Administrator, respectively. The current exception to this general rule of exclusive authority, which we propose to continue, is that the discretion of an intermediary or intermediary hearing officer(s) to reopen or not reopen an intermediary determination or intermediary hearing decision is subject to a directive from CMS to reopen or not reopen.

In paragraph (c)(1) we would specify that CMS may direct an intermediary or intermediary hearing officer(s) to reopen and revise an intermediary determination or intermediary hearing officer(s) decision by providing explicit direction to the intermediary or hearing officer(s) to reopen and revise, and that CMS's authority is constrained only by the time limits set forth in proposed paragraph (b) and the limitation in proposed paragraph (c)(1)(ii) (discussed below). As we stated in the August 1, 2002 final rule (67 FR 50096–97), the purpose of requiring an explicit direction to reopen and revise is to prevent any misunderstanding as to whether CMS has directed a reopening, including a claim that CMS has impliedly directed a reopening through publication or issuance of a change in policy.

In proposed paragraph (c)(1)(i), we would give two examples of CMS-directed reopenings. The first example is where CMS provides explicit notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary. This example, as recently clarified by the August 1, 2002 final rule, has been in § 405.1885(b) of our regulations since its inception. We propose to place it under the heading of ''Example'' to further reinforce the discretionary nature of reopenings, including CMS-directed reopenings, and to avoid implying that CMS must direct an intermediary or intermediary hearing officer(s) to reopen in such a situation. Our proposed second example of a CMS-directed reopening currently appears (with slight, non-substantive wording differences) at § 405.1885(b)(3). It was added by the August 1, 2002 final rule in response to our concern that the clarifications proposed for that rule might be misinterpreted as meaning that CMS would be precluded from requiring the reopening of a particular intermediary determination or decision in order to implement a specific final agency decision, final and non-appealable court judgment or a specific agreement to settle an administrative appeal or a lawsuit. See 67 FR 50099.

In paragraph (c)(1)(ii) we would provide that a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a CMS or intermediary determination, an intermediary hearing decision, a CMS reviewing official decision, a Board decision, or an Administrator decision, under this section. We explained in the August 1, 2002 final rule that it was never our policy to require intermediaries to reopen based on a change in legal interpretation or policy, regardless of the impetus of such change, and that intermediary reopenings based on a change in legal interpretation or policy would raise questions of impermissible retroactive rulemaking. See 67 FR 50096. The August 1, 2002 final rule made clear that intermediary and intermediary hearing officer(s) reopenings based on a change in legal interpretation or policy are not permitted, and we believe that fairness and concerns of possible impermissible retroactive rulemaking dictate that we should extend such a prohibition on such reopenings to CMS (with respect to Secretary determinations), CMS reviewing officials, the Board, and the Administrator.

In proposed paragraphs (c)(3) and (c)(4), we would clarify the authority, and specify the procedures, for intermediary reopenings in two specific situations. In proposed paragraph (c)(3), we would state that the intermediary may reopen, on its own motion or on request, a determination that is currently pending on appeal before the Board or the Administrator. The scope of the reopening could include any matter covered by the determination, including those specific matters that have been appealed to the Board or the Administrator. The intermediary would be required to notify the Board of the reopening. In proposed paragraph (c)(4) we would provide that an intermediary may reopen, on its own motion or on request of the provider(s), a determination for which no appeal has been taken, but for which the time to appeal to the Board has not yet expired.

Finally, we would delete as unnecessary current § 405.1885(f) which relates to cost reporting periods ending prior to December 31, 1971.

2. Required Notices Under Reopening Procedures; Effect of a Reopening (§ 405.1887)

In proposed § 405.1887 we would specify the obligations of the intermediary or reviewing entity, as applicable, to: (1) Provide written notice to all parties of its intention to reopen; (2) to allow the parties a reasonable period of time in which to present any additional evidence or argument in support of their positions; and (3) to notify all parties, at the conclusion of the reopening, of the results of the reopening, including any revisions that have been made.

Our proposed language for § 405.1887(d) is meant to state our longstanding policy that a reopening of a determination by itself does not extend appeal rights, and that any matter that is considered during the course of a reopening (including a matter specifically identified in a notice of reopening) but is not revised is not within the proper scope of an appeal of a revised determination or decision (see § 405.1889). In *Edgewater Hospital* v. *Bowen,* 857 F.2d 1123 (7th Cir. 1989), the intermediary issued an NPR and, following a reopening, a revised NPR. The provider appealed the disallowance of two items that were addressed in the original NPR and which were identified in the notice of reopening, but were not revised in the revised NPR. The appeal was within 180 days after the revised NPR, but more than 180 days after the original NPR. Based on the ''clear language of the Regulations,'' the court of appeals found that the provider's appeal was timely. The court held that the intermediary's decision to review

the two disputed cost items during the course of its reopening was a revision within the meaning of the regulations, despite the fact that the intermediary did not revise the disallowances with respect to those items. The proposed language in paragraph (d) is intended to make clear that items that are within the scope of a reopening but are not revised, are not appealable through any revised determination issued after the reopening. See also proposed § 405.1889. For example: An intermediary issues an NPR on March 1, 2001. No timely appeal of the NPR is taken. On December 1, 2001 the intermediary notifies the provider that it intends to reopen the March 1, 2001 NPR to examine cost issues A, B, and C. On June 1, 2001 the intermediary issues a revised NPR which addresses only cost issue C. The provider has 180 days from its receipt of the June 1, 2001 revised NPR to appeal cost issue C (assuming the amount in controversy and dissatisfaction requirements are met); any appeal of cost issues A and/or B would be untimely and would be disallowed, because issues A and B were not revised.

We note that in *Edgewater,* the provider still had time to appeal the first NPR at the time that the intermediary issued its notice of reopening. The district court stated that the provider was unaware that the two cost items that it appealed (from the revised NPR) were not going to be revised until it received the revised NPR (at which time it was too late to appeal them from the original NPR). The court of appeals indicated that its decision may have in part been based on fairness concerns. We do not believe, however, that a provider should assume that cost items that have been reopened will necessarily be revised at all, or revised in a fully favorable way to the provider.

3. Effect of a Revision; Issue-Specific Nature of Appeals of Revised Determinations and Decisions (§ 405.1889)

We propose to change the title of § 405.1889 and to make minor revisions to the language. Our proposed changes are intended to clarify our longstanding policy, which is expressed in current § 405.1889 and which has been upheld by several courts, that the scope of appeal of a revised notice of amount of program reimbursement (NPR) or other revised determination or revised decision is limited to the specific revisions that were made in the revised determination or decision. That is, if the time to raise a matter through an appeal of the original determination or decision has expired, the matter may not be appealed through an appeal of a revised determination or decision if the matter has not been specifically revised in the revised determination or decision. (See, for example, *Foothill Presbyterian Hosp.* v. *Shalala,* 152 F.3d 1132 (9th Cir. 1998); *HCA Health Servs. of Oklahoma, Inc.* v. *Shalala,* 27 F.3d 614, 618 (D.C. Cir. 1994)). For example: After the time to appeal an NPR has expired, an intermediary reopens the NPR and issues a revised NPR, which reclassifies the provider's malpractice insurance costs as administrative and general expenses not subject to the routine cost limits (RCL). The provider appeals the revised NPR to the Board, and challenges the methodology by which the RCL were calculated. Although the RCL were necessarily affected by the revised NPR, the revised NPR made no revision to the methodology for calculating the RCL; therefore the provider's appeal is not within the scope of the revised NPR and the Board is without jurisdiction to hear the appeal.

W. Three Additional Proposals Under Consideration

We are considering whether to amend our regulations to state the following. First, an ex parte contact with a Board staff member concerning a procedural matter in a case is not a prohibited ex parte communication. We believe this proposed position is consistent with how courts operate with respect to communications between one party's attorney and the judge's clerk or the court's docket staff. We would also encourage counsel to keep such communications to a minimum and to notify promptly opposing counsel whenever such communications take place.

Second, upon receipt of a credible allegation that a party's counsel has a conflict of interest in his or her representation of the party, the Board has the responsibility to order such party to show cause why a case should not be dismissed or why other appropriate action should not be taken. We believe that in order to maintain the integrity of the appeal process, a representative that has, or may have, obtained confidential information from one party while in that party's employ should not represent another party whose interest is inimical to that of the first party. An allegation that a conflict of interest has occurred should not be made nor taken lightly.

Third, where an intermediary denies reimbursement for a claimed item without auditing the reimbursement effect of such claim, and the intermediary's denial is reversed by a decision of the Board, the Administrator or a court, which has become final and non-appealable, CMS may require the intermediary to determine the reimbursement effect of the claim prior to payment. (This position is similar to our proposal for § 405.1803(d), as previously stated, for the auditing of self-disallowed costs.) Similarly, where CMS or the intermediary denies reimbursement for an item on one basis and that determination is reversed, CMS or the intermediary should then have the opportunity to determine whether reimbursement should be allowed or whether reimbursement should be denied for any other reason. For example, if CMS were to deny a provider's request for an exception to its ESRD payment rate on the basis that the request was not submitted timely, and if this determination were reversed by a court order that has become final and non-appealable, CMS would then determine whether the provider's exception request is allowable — the exception request would not be granted simply because the court found that it was timely submitted. This latter proposal is consistent with our longstanding view and we believe it is appropriate in light of the need to conserve administrative resources. That is, we believe that it is potentially a waste of resources for a decision maker to consider all possible reasons why an item or request should not be allowed where the decision maker has a good faith belief that its determination is correct and that determination may never be challenged or, if it is challenged, may never be reversed.

Issues relating to these proposals did not surface until very late in the development of this proposed rule. We did not wish to delay publication of the proposed rule, so we have not set forth specific regulatory text language for these proposals. Rather, we are providing the public with notice of the proposals and we invite comments on them.

X. Technical Revisions

1. Sections 413.30(c)(1), 413.30(c)(2), 413.40(e)(5)

These sections provide that the time required by CMS or the intermediary to review a request for an exception or exemption to the routine cost limits or a request for an adjustment to the rate-of-increase ceiling for a hospital excluded from PPS is good cause for the granting of an extension of time in which to seek a Board hearing on an appeal of the intermediary's NPR. We propose to revise the language to provide that the time in which to seek

an intermediary hearing under the above circumstances is also extended for good cause. We also propose to delete the references to § 405.1841 (which we propose to delete) in these sections and replace them with references to proposed new § 405.1836.

2. Section 413.64(j)(1)

We propose to make minor, non-substantive wording changes and to replace the reference to § 405.1841 with a reference to § 405.1835.

3. Sections 417.576, 417.810

As we explain above, we propose to revise § 405.1801(b)(2) to clarify the specific applicability of subpart R to non-provider entities. We believe the regulation is incomplete in stating that non-provider entities do not qualify for a Board hearing, because, under our longstanding policy, such entities cannot qualify for a Board hearing or an intermediary hearing because both types of hearings are available only to providers. Also as stated above, we believe that non-provider hearings before a CMS reviewing official are more analogous to a Board hearing than an intermediary hearing, and we propose to revise § 405.1801(b)(2) to state that if a hearing is available to a non-provider entity on an amount in controversy of at least $1,000, the procedural rules for a Board hearing under this subpart are applicable to the maximum extent possible. Accordingly, we also propose to revise §§ 417.576(d)(4), 417.810(c)(2) and 417.810(d)(3) to substitute ''a hearing in accordance with the procedural rules described in § 405.1801(b)(2)'' in place of language that states or implies that a health maintenance organization (HMO) or competitive medical plan (CMP) has a right to a hearing in accordance with, or under, Subpart R.

III. Collection of Information Requirements

[If you choose to comment on issues in this section, please include the caption ''Collection of Information Requirements'' at the beginning of your comments.]

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

For the purpose of discussion, below is a summary of the information collection requirements associated with the hearing process. Because these collection requirements are collected pursuant to an administration action and/or audit they are not subject to the PRA, as stipulated under 5 CFR 1320.4.

Section 405.1811 Right to Intermediary Hearing; Contents of, and Adding Issues to, Hearing Request

The provider's request for an intermediary hearing must be submitted in writing to the intermediary, and the request must include specified information.

After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the intermediary hearing officer, only if certain conditions are met.

The exempt burden associated with these requirements is the time it will take a provider to gather all the necessary information and to write the request for an intermediary hearing. The proposed regulation would not impose any new paperwork burdens on providers. It would merely require providers to prepare their requests in a more expedited fashion. Because most cost report disputes involve at least $10,000 and are therefore heard by the Board, only a handful of intermediary hearing requests are submitted annually by providers.

Section 405.1835 Right to Board Hearing; Contents of, and Adding Issues to, Hearing Request

The provider's request for a Board hearing must be submitted in writing to the intermediary, and the request must include specified information.

After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the intermediary hearing officer, only if certain conditions are met.

The exempt burden associated with these requirements is the time it will take a provider to gather all the necessary information and to write the request for a Board hearing. The proposed regulation would not impose any new paperwork burdens on providers. It would merely require providers to prepare their requests in a more expedited fashion. Generally speaking, appeal letters are two to five pages long and the time required to put together and mail the appeal letter is minimal. The number of requests for appeal received by the Board varies from year to year. For FY 2000, the Board received 4053 new appeals and in 2003, the Board received 1675 new appeals. We welcome comments on this burden.

Section 405.1837 Group Appeals

The providers' request for a group appeal must be submitted in writing to the Board, and the request must include specified information. A provider may be added to the group after requesting to do so in writing.

The exempt burden associated with these requirements is the time it will take a group to gather all the necessary information and to write the request. In the last two years, an average of 325 groups filed requests for Board hearings and each had to submit additional information.

IV. Response To Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, if we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption ''Regulatory Impact Statement'' at the beginning of your comments.]

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA), September 16, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995, Pub. L. No. 104–4, and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential

economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any one year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and we certify, that this rule will not have a significant economic impact on a substantial number of small entities. The only burden attached to this proposed rule is the information collection burden associated with filing a request for an intermediary or PRRB hearing. As we have described in section III of this preamble, the proposed rule does not impose any new paperwork burdens on providers. It merely proposes requiring providers to prepare their hearing requests in a more expedited fashion. Moreover, the proposed rule would lessen the time it takes small entities to pursue appeals and receive decisions.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing analyses for section 1102(b) of the Act because we have determined, and we certify, that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals. Again, the only impact on small rural hospitals would be the potential increase in the amount of time a provider would need to file a request for an intermediary or PRRB hearing. However, as we described in section III of this preamble, the proposed rule does not impose any new paperwork burdens on providers. It merely proposes requiring providers to prepare their hearing requests in a more expedited fashion. Moreover, the proposed rule would lessen the time it takes rural hospitals to pursue appeals and receive decisions.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule will have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Because this regulation does not impose any costs on State or local governments, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 417

Administrative practice and procedure, Grant programs—health, Health care, Health insurance, Health maintenance organizations (HMO), Loan programs—health, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV would be amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart R—Provider Reimbursement Determinations and Appeals

1. The authority citation for part 405, subpart R continues to read as follows:

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).

2. Section 405.1801 is amended to read as follows:

A. In paragraph (a), remove the words ''Administrator's review'' and add in their place, the words ''Administrator review''; the terms ''date of filing'' and ''date of submission of materials'' are removed; and the definition for the term ''date of receipt'' is revised; definitions for ''CMS reviewing official'', ''CMS reviewing official procedure'', ''intermediary hearing officer(s)'', and ''reviewing entity'' are added in alphabetical order.

B. Paragraph (b) is revised.

C. A new paragraph (d) is added.

The revisions and additions read as follows:

§ 405.1801 Introduction.

(a) Definitions. * * *

* * * * *

CMS reviewing official means the reviewing official provided for in § 405.1834.

CMS reviewing official procedure means the review provided for in § 405.1834.

* * * * *

Date of receipt means the date a document or other material is received by: (1) A party or an affected non-party, such as CMS, involved in proceedings before a reviewing entity; or (2) a reviewing entity. The date of receipt by a party or affected nonparty involved in proceedings before a reviewing entity is presumed to be 5 days after the date of issuance of an intermediary notice or a reviewing entity document, or 5 days after the date of submission of material to a reviewing entity, as applicable, unless it is established by a preponderance of the evidence that the intermediary notice, reviewing entity document, or submitted material was actually received on a later date. As applied to a provider, 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.

The date of receipt by a reviewing entity is presumed as the date stamped by the reviewing entity ''Received'' on the document or other submitted material, unless it is established by a preponderance of the evidence that the document or other material was actually received on a different date. For purposes of an intermediary hearing, if no intermediary hearing officer is appointed (or none is currently presiding), the date of receipt of an intermediary hearing request (or other material pertaining to the request) is presumed to be the date stamped ''Received'' on the material by the

intermediary, unless it is established by a preponderance of the evidence that the document or other material was actually received on a different date. The date of receipt of a document or other material by a CMS reviewing official or the CMS Administrator is presumed to be the date stamped ''Received'' on the material by the Office of the Attorney Advisor, unless it is established by a preponderance of the evidence that the document or other material was actually received on a different date.

Intermediary hearing officer(s) means the hearing officer or panel of hearing officers provided for in § 405.1817.

* * * * *

Reviewing entity means the intermediary 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 intermediary as specified in § 413.24(f) of this chapter. For purposes of this subpart, the term ''provider'' includes a hospital (see part 482 of this chapter), hospice program (see § 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 non-provider entities participating in Medicare Part A*.

(i) In addition to providers of services, there are other entities such as health maintenance organizations (HMOs) and competitive medical plans (CMPs) (see § 400.200 of this chapter) that may participate in the Medicare program but do not qualify as providers under the Act or this subpart.

(ii) Some of these non-provider entities are required to file periodic cost reports and are paid on the basis of information furnished in these reports. These non-provider entities may not obtain an intermediary hearing or a Board hearing under the Act or this subpart.

(iii) Some other hearing may be available to these non-provider entities, if the amount in controversy is at least $1,000.

(iv) For any non-provider hearing, the procedural rules for a Board hearing set forth in this subpart are applicable to the maximum extent possible.

* * * * *

(d) *Calculating time periods and deadlines*. In computing any period of time or deadline prescribed or allowed under this subpart or authorized by a reviewing entity:

(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 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) The last day of the designated time period is included unless it is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or, in the case of a deadline for receipt by a reviewing entity (see § 405.1801(a)), a day when 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 continues to run until the end of the next day which is not one of the aforementioned days.

(4) For purposes of paragraph (d) of this section, the reviewing entity is deemed to—

(i) Be the intermediary, if the intermediary hearing officer(s) is not yet appointed (or none is currently presiding); and

(ii) Include the Office of the Attorney Advisor.

3. Section 405.1803 is amended to read as follows:

A. In the first sentence of paragraph (a) introductory text, remove the citation ''(see § 405.1835(b))'' and add in its place ''(see § 405.1835(a)(3)(ii))'';

B. In the second sentence of paragraph (b), remove the phrase ''after the date of the notice.'' and add in its place ''after the date of receipt of the notice.'';

C. A new paragraph (d) is added to read as follows:

§ 405.1803 Intermediary determination and notice of amount of program reimbursement.

* * * * *

(d) *Effect of certain final agency decisions and final court judgments; audits of self-disallowed items*.

(1) This paragraph applies to the following administrative decisions and court judgments:

(i) A final hearing decision by the intermediary (see § 405.1833) or the Board (see § 405.1871(b)).

(ii) A final decision by a CMS reviewing official (see § 405.1834(f)(1)) or the Administrator (see § 405.1875(e)(4)) following review of a hearing decision by the intermediary or the Board, respectively.

(iii) A final, non-appealable judgment by a court on a Medicare reimbursement issue that the court rendered in accordance to jurisdiction under section 1878 of the Act (see § 405.1842 and § 405.1877).

(2) For any final agency decision or final court judgment specified in paragraph (d)(1) of this section, the intermediary must promptly, upon notification from CMS:

(i) Determine the effect of the final decision or judgment on the intermediary determination for the cost reporting period at issue in the decision or judgment.

(ii) Issue any revised intermediary determination, and make any additional program payment, or recoup or offset any program payment (see § 405.371), for the period that may be necessary to implement the final decision or judgment on the specific matters at issue in the decision or judgment.

(3) CMS may require the intermediary to audit any self-disallowed item at issue in an appeal or a civil action before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

(4) For any final settlement agreement, whether for an appeal to the intermediary hearing officer(s) or the Board or for a civil action before a court, the intermediary must implement the settlement agreement in accordance with paragraphs (d)(2) and (d)(3) of this section, unless a particular administrative or judicial settlement agreement provides otherwise.

4. Section 405.1811 is revised to read as follows:

§ 405.1811 Right to intermediary hearing; contents of, and adding issues to, hearing request.

(a) *Criteria*. A provider (but no other individual, entity, or party) has a right to an intermediary hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary

determination for the period, but only if—

(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either:

(i) Including a claim for a specific item(s) on its cost report for a period if the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Self-disallowing a specific item(s) by following the applicable procedures for filing a cost report under protest, if the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

(2) The amount in controversy (as determined in accordance with § 405.1839) is at least $1,000 but less than $10,000; and

(3) Unless the provider qualifies for a good cause extension under § 405.1813, the date of receipt by the intermediary of the provider's hearing request must be—

(i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; or

(ii) Where the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12-month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped ''Received'' unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

(b) *Contents of request for an intermediary hearing*. The provider's request for an intermediary hearing must be submitted in writing to the intermediary, and the request must include:

(1) A demonstration that the provider satisfies the requirements for an intermediary hearing as specified in paragraph (a) of this section, including a specific identification of the intermediary or Secretary determination under appeal.

(2) An explanation, for each specific item at issue (see § 405.1811(a)(1)), of the provider's dissatisfaction with the intermediary or Secretary determination under appeal, including an account of:

(i) Why the provider believes Medicare payment is incorrect for each disputed item.

(ii) How and why the provider believes Medicare payment should be determined differently for each disputed item.

(iii) Where the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for any item.

(3) A copy of the intermediary 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) *Adding issues to the hearing request*. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the intermediary hearing officer, only if:

(1) A hearing request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.

(2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.

(3) The intermediary hearing officer receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.

5. Section 405.1813 is revised to read as follows:

§ 405.1813 Good cause extension of time limit for requesting an intermediary hearing.

(a) A request for an intermediary hearing that is received by the intermediary after the applicable 180-day time limit prescribed in § 405.1811(a)(3) must be dismissed by the intermediary hearing officer(s), except the hearing officer(s) may extend the time limit upon a good cause showing by the provider.

(b) The intermediary 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 intermediary hearing officer(s) within a reasonable time (as determined by the intermediary hearing officer(s) under the circumstances) after the expiration of the applicable 180-day limit prescribed in § 405.1811(a)(3).

(c) The intermediary 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 intermediary of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

(d) If an extension request is granted or denied under this section, the intermediary hearing officer(s) must give prompt written notice to the provider, and mail 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) or reopened by the intermediary hearing officer(s) in accordance with § 405.1885 through § 405.1889. The intermediary hearing officer(s) will promptly mail the decision to CMS' Office Hearings (see § 405.1834(b)(4)).

(2) A decision granting an extension request under this section is not subject to immediate review by a CMS reviewing official (see § 405.1834(b)(3)). Any decision may be examined during the course of CMS review of a final jurisdictional dismissal decision or a final hearing decision by the intermediary hearing officer(s) (see § 405.1834(b)(2)(i) and (ii)).

6. A new section 405.1814 is added to read as follows:

§ 405.1814 Intermediary hearing officer jurisdiction.

(a) *General rules*. (1) After a request for an intermediary hearing is filed under § 405.1811, the intermediary hearing officer(s) must:

(i) Determine in accordance with paragraph (b) of this section, whether it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.

(ii) Make a preliminary determination of the scope of its jurisdiction, if any,

over the matters at issue in the appeal, and notify the parties of its specific jurisdictional findings, before conducting any of the following proceedings:

(A) Determining its authority to decide a legal question relevant to a matter at issue (see § 405.1829);

(B) Permitting discovery (see § 405.1821); or conducting a hearing (see § 405.1819);

(C) May revise a preliminary jurisdictional finding at any subsequent stage of the proceedings in an appeal, and it must promptly notify the parties of the revised findings.

(2) Under paragraph (c)(1) of this section, each intermediary hearing decision (see § 405.1831) must include a final jurisdictional finding for each specific matter at issue in the appeal.

(3) If the hearing officer(s) finally determines it lacks jurisdiction over every specific matter at issue in the appeal, it issues a jurisdictional dismissal decision under paragraph (c)(2) of this section.

(4) Final jurisdictional findings and jurisdictional dismissal decisions by the hearing officer(s) are subject to the CMS reviewing official procedure in accordance with paragraph (d) of this section and § 405.1834(b)(2)(i) and (b)(2)(ii).

(b) *Criteria.* Except for the amount in controversy requirement, the jurisdiction of the intermediary hearing officer(s) to grant a hearing is determined separately for each specific matter at issue in the intermediary or Secretary determination for the cost reporting period under appeal. The hearing officer(s) has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to an intermediary hearing under § 405.1811. Certain matters at issue are removed from the jurisdiction of the intermediary hearing officer(s); these matters include, but are not limited to, the following:

(1) A finding in an intermediary determination that no payment be made under title XVIII of the Act for expenses incurred for items and services furnished to an individual because those items and services are excluded from coverage under section 1862 of the Act, 42 U.S.C. 1395y, and the regulations at 42 CFR, Part 411 (the finding may be reviewed only in accordance with the applicable provisions of section 1869 of the Act, and of subpart G or H of part 405).

(2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in § 405.1804.

(3) Any self-disallowed item except as permitted in § 405.1811(a)(1)(ii).

(c) *Final jurisdictional findings and jurisdictional dismissal decisions by intermediary hearing officer(s).*

(1) In issuing a hearing decision under § 405.1831, the intermediary hearing officer(s) must make a final determination of its jurisdiction, or lack thereof, for each specific matter at issue in the hearing decision. Each intermediary hearing decision must include specific findings of fact and conclusions of law as to the jurisdiction of the hearing officer(s), or lack thereof, to grant a hearing on each matter at issue in the appeal.

(2) If the hearing officer(s) finally determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a jurisdictional dismissal decision dismissing the appeal for lack of jurisdiction. Each jurisdictional dismissal decision by the hearing officer(s) must include specific findings of fact and conclusions of law explaining the determination that there is no jurisdiction to grant a hearing on each matter at issue in the appeal. A copy of the jurisdictional dismissal decision must be mailed promptly to each party to the appeal (see § 405.1815) and to CMS' Office of Hearings (see § 405.1834(b)(4)).

(3) A jurisdictional dismissal decision by the intermediary hearing officer(s) under paragraph (c)(2) of this section is final and binding on the parties unless the decision is reviewed by a CMS reviewing official in accordance with § 405.1834 or reopened by the intermediary hearing officer(s) in accordance with §§ 405.1885 through 405.1889.

(d) *CMS reviewing official procedure.* Any finding by the intermediary hearing officer(s) as to whether it has jurisdiction to grant a hearing on a specific matter at issue in an appeal is not subject to immediate review by a CMS reviewing official, except as provided in this paragraph (see § 405.1834(b)(3)). A CMS reviewing official may review under § 405.1834(b)(2)(ii) or (b)(2)(iii) the final jurisdictional findings of the intermediary hearing officer(s) as to specific matters at issue in an appeal, provided these findings are included in a jurisdictional dismissal decision under paragraph (c)(2) of this section or a hearing decision (see § 405.1831) by the intermediary hearing officer(s).

7. Section 405.1815 is revised to read as follows:

§ 405.1815 Parties to proceedings before the intermediary hearing officer(s).

When a provider files a request for an intermediary hearing in accordance with § 405.1811, the parties to all proceedings before the intermediary hearing officer(s) are the provider and, if applicable, any other entity found by the intermediary to be a related organization of the provider under § 413.17 of this chapter. The parties must be given reasonable notice of the time, date, and place of any intermediary hearing. Neither the intermediary nor CMS may be made a party to proceedings before the intermediary hearing officer(s).

8. Section 405.1821 is revised to read as follows:

§ 405.1821 Prehearing discovery and other proceedings prior to the intermediary hearing.

(a) *Discovery rule; time limits.* (1) Limited prehearing discovery may be permitted by the intermediary hearing officer(s) upon request of a party, provided the request is timely and the hearing officer(s) makes a preliminary finding of its jurisdiction over the matters at issue in accordance with § 405.1814(a).

(2) A prehearing discovery request is timely if the date of receipt of the request by another party, or non-party, as applicable, is no later than 90 days before the scheduled starting date of the intermediary hearing, unless the intermediary hearing officer(s) extend the time upon request of the party and upon a showing of good cause.

(3) Discovery may not be authorized by the hearing officer(s) or conducted by a party any later than 45 days before the scheduled starting date of the intermediary hearing unless the hearing officer(s) find, at the request of the party, good cause to extend the period for discovery.

(4) Before ruling on a request to extend the time for requesting discovery or for conducting discovery, the hearing officer(s) must give the other parties to the appeal and any non-party subject to a discovery request a reasonable period to respond to the extension request.

(5) The hearing officer(s) may extend the time in which to request discovery or conduct discovery only if the requesting party establishes that it was not dilatory or otherwise at fault in not meeting the original discovery deadline.

(6) If the extension request is granted, the hearing officer(s) must impose a new deadline and, if necessary, reschedule the hearing date so that all discovery ends no later than 45 days before the hearing.

(b) *Discovery criteria*—(1) *General rule*. The intermediary hearing officer(s) may permit discovery of a matter that is relevant to the specific subject matter of the intermediary hearing, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate. In determining whether to permit discovery and in fixing the scope and limits of any discovery, the hearing officer(s) uses the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence for guidance.

(2) *Limitations on discovery*. Any discovery before the intermediary hearing officer(s) is limited as follows:

(i) A party may request of another party or a non-party the reasonable production of documents for inspection and copying, and may propound a reasonable number of written interrogatories.

(ii) A party may not request admissions, take oral or written depositions, or take any other form of discovery not permitted under this section.

(c) *Discovery procedures; rights of non-parties; motions to compel or for protective order*. (1) A party may request discovery of another party to the proceedings before the intermediary hearing officer(s) or of a non-party to the proceedings. Any discovery request filed with the intermediary hearing officer(s) must be mailed promptly to the party or non-party from which the discovery is requested, and to any other party to the intermediary hearing (see § 405.1815).

(2) If a discovery request is made of a non-party to the intermediary hearing, the non-party (including HHS and CMS) has the same rights as any party has in responding to a discovery request. These rights include, but are not limited to, the right to select and use any attorney or other representative, and to submit discovery responses, objections, or motions to the hearing officer(s).

(3) Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a non-party.

(i) A party may submit to the intermediary hearing officer(s) a motion to compel discovery that is permitted under this section, and a motion for a protective order regarding any discovery request may be submitted to the hearing officer(s) by a party or non-party.

(ii) Any motion to compel or for protective order must include a self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute. The declaration also must be included with any response to a motion to compel or for a protective order.

(iii) The hearing officer(s) must—

(A) Decide the motion in accordance with this section and any prior discovery ruling; and

(B) Issue and mail to each party and any affected non-party a discovery ruling that grants or denies the motion to compel or for protective order in whole or in part; if applicable, the discovery ruling must specifically identify any part of the disputed discovery request upheld and any part rejected, and impose any limits on discovery the hearing officer(s) find necessary and appropriate.

(d) *Reviewability of discovery or disclosure rulings*—

(1) *General rule.* A discovery ruling issued in accordance with paragraph (c)(3) of this section, or a disclosure ruling (such as one issued at a hearing), is not subject to immediate review by a CMS official (see § 405.1834(b)(3)). A discovery ruling may be examined solely during the course of CMS review under § 405.1834 of a jurisdictional dismissal decision (see § 405.1814(c)(2)) or a hearing decision (see § 405.1831) by the intermediary hearing officer(s).

(2) *Exception.* To the extent a ruling authorizes discovery or disclosure of a matter for which an objection based on privilege or other protection from disclosure was made before the intermediary hearing officer(s), that portion of the discovery or disclosure ruling may immediately be reviewed by a CMS reviewing official in accordance with § 405.1834(b)(3). Upon notice to the intermediary hearing officer that the provider intends to seek immediate review of a ruling, or that the intermediary intends to suggest that the Administrator take own motion review of the ruling, the intermediary hearing officer stays all proceedings affected by the ruling. The intermediary hearing officer under the circumstances of a given case must determine the length of any stay, but in no event must be less than 10 days. If the Administrator grants a request for review, or takes own motion review, of a ruling, the ruling is stayed until the time as the CMS reviewing official issues a written decision that affirms, reverses, modifies, or remands the intermediary hearing officer's ruling. If the Administrator does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the ruling stands.

(e) *Prehearing conference.* The intermediary hearing officer(s) has discretion to schedule a prehearing conference. A prehearing conference may be conducted in person or telephonically, at the discretion of the intermediary hearing officer(s). When a panel of intermediary hearing officers is designated, the panel may appoint one or more hearing officers to act for the panel for any prehearing conference or any matter addressed at the conference.

9. Section 405.1827 is revised to read as follows:

§ 405.1827 Record of proceedings before the intermediary hearing officer(s).

(a) The intermediary hearing officer(s) must maintain a complete record of all proceedings in an appeal.

(b) The record consists of all documents and any other tangible materials timely submitted to the hearing officer(s) by the parties to the appeal and by any non-party (see § 405.1821(c)), along with all correspondence, rulings, orders, and decisions (including the final decision) issued by the hearing officer(s).

(c) The record must include a complete transcription of the proceedings at any intermediary hearing.

(b) A copy of the transcription must be made available to any party upon request.

10. Section 405.1829 is amended to read as follows:

A. In paragraph (a), remove the parenthetical phrase ''(see 42 CFR 401.108),'' and add, in its place, ''(see 401.108 of this chapter for a description of CMS Rulings),'';

B. The section heading and paragraph (b) are revised to read as follows:

§ 405.1829 Scope of authority of intermediary hearing officer(s).

* * * * *

(b)(1) If the intermediary hearing officer(s) has jurisdiction to conduct a hearing on the specific matters at issue under § 405.1811, and the legal authority to fully resolve the matters in a hearing decision (see § 405.1831), the hearing officer(s) must affirm, modify, or reverse the intermediary's findings on each specific matter at issue in the intermediary or Secretary determination for the cost year under appeal.

(2) The intermediary hearing officer(s) also may make additional revisions on specific matters regardless of whether the intermediary considered the matters in issuing the intermediary determination for the cost year, provided the hearing officer(s) does not consider or decide any specific matter for which it lacks jurisdiction (see § 405.1814(b)) or which was not timely raised in the provider's hearing request.

(3) The authority of the intermediary hearing officer(s) under this paragraph

to make the additional revisions is limited to those revisions necessary to fully resolve a specific matter at issue if—

(i) The hearing officer(s) has jurisdiction to grant a hearing on the specific matter under § 405.1811 and § 405.1814; and

(ii) The specific matter was timely raised in an initial request for an intermediary hearing filed in accordance with § 405.1811(b) or in a timely request to add issues to an appeal submitted in accordance with § 405.1811(c).

11. Section 405.1831 is revised to read as follows:

§ 405.1831 Intermediary hearing decision.

(a) If the intermediary hearing officer(s) finds jurisdiction and conducts a hearing (see § 405.1814(a)) the hearing officer(s) must promptly issue a written hearing decision.

(b) The intermediary hearing decision must be based on the evidence from the intermediary hearing (see § 405.1823) and other evidence as may be included in the record (see § 405.1827).

(c) The decision must include findings of fact and conclusions of law on jurisdictional issues (see § 405.1814(c)(1)) and on the merits of the provider's reimbursement claims, and include appropriate citations to the record evidence and to the applicable law, regulations, CMS Rulings, and general CMS instructions.

(d) A copy of the decision must be mailed promptly to each party and to CMS's Office of Hearings (see § 405.1834(b)(4)).

12. Section 405.1833 is revised to read as follows:

§ 405.1833 Effect of intermediary hearing decision.

An intermediary hearing decision issued in accordance with § 405.1831 is final and binding on all parties to the intermediary hearing and the intermediary unless the hearing decision is reviewed by a CMS reviewing official in accordance with § 405.1834 or reopened by the intermediary hearing officer(s) in accordance with § 405.1885 through § 405.1889. Final intermediary hearing decisions are subject to the provisions of § 405.1803(d).

13. A new section 405.1834 is added to read as follows:

§ 405.1834 CMS reviewing official procedure.

(a) *Scope.* A provider that is a party to, and dissatisfied with, a final decision by the intermediary hearing officer(s) may request further administrative review of a decision, or the decision may be reviewed at the discretion of the Administrator. No other individual, entity, or party has the right to the review. The review is conducted on behalf of the Administrator by a designated CMS reviewing official who considers whether the decision of the intermediary hearing officer(s) is consistent with the law and the evidence in the record. Based on the review, the CMS reviewing official issues a decision on behalf of the Administrator.

(b) *General rules.* (1) A CMS reviewing official may immediately review any final decision of the intermediary hearing officer(s) as specified in paragraph (b)(2) of this section; and non-final decisions and other non-final actions by the intermediary hearing officer(s) are not immediately reviewable, except as provided in paragraph (b)(3) of this section. The Administrator may exercise this review authority in response to a request from a provider party to the appeal or at his or her discretion.

(2) A CMS reviewing official may immediately review:

(i) Any final jurisdictional dismissal decision by the intermediary hearing officer(s), including any finding that the provider failed to demonstrate good cause for extending the time in which to request a hearing (see § 405.1813(e)(1) and § 405.1814(c)(3)); and

(ii) Any final intermediary hearing decision (see § 405.1831).

(3) Non-final decisions and other non-final actions by the intermediary hearing officer(s) are not subject to the CMS reviewing official procedure until the intermediary hearing officer(s) issues a final decision as specified in paragraph (b)(2) of this section (see § 405.1813(e)(2), § 405.1814(d), and § 405.1821(d)(1)), except a CMS reviewing official may, but is not required to, immediately review any intermediary hearing officer ruling (including a ruling made during the course of the hearing) authorizing discovery or disclosure of a matter for which an objection was made based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden (see § 405.1821(d)(2)).

(4) In order to facilitate the Administrator's exercise of this review authority, the intermediary hearing officer(s) must promptly send copies of any decision specified in paragraph (a)(2) of this section or § 405.1821(d)(2) to CMS's Office of Hearings.

(i) All requests for review by a CMS reviewing official and all written submissions to a CMS reviewing official under paragraphs (c) and (d) of this section also must be sent to CMS'' Office of Hearings.

(ii) The Office of Hearings examines each intermediary hearing officer decision that is reviewable under paragraph (b)(2) of this section or § 405.1821(d)(2), along with any review requests and any other submissions made by a party in accordance with the provisions of this section, in order to assist the Administrator's exercise of this review authority.

(c) *Request for review.* (1) A provider's request for review by a CMS reviewing official is granted if:

(i) The date of receipt by the Office of Hearings of the review request is no later than 60 days after the date of receipt by the provider of the intermediary hearing officer decision.

(ii) The request seeks review of a decision listed in paragraph (b)(2) of this section, and the provider complies with the requirements of paragraph (c)(2) of this section.

(2) The provider must submit its request for review in writing, attach a copy of the intermediary decision for which it seeks review and include a brief description of:

(i) Those aspects of the intermediary hearing officer decision with which the provider is dissatisfied.

(ii) The reasons for the provider's dissatisfaction.

(iii) Any argument or record evidence the provider believes supports its position.

(iv) Any additional, extra-record evidence relied on by the provider, along with a demonstration that the evidence was improperly excluded from the intermediary hearing (see § 405.1823).

(3) A provider request for immediate review of an intermediary hearing officer ruling authorizing discovery or disclosure in accordance with paragraph (b)(3) of this section must:

(i) Be made as soon as practicable after the ruling is made, but in no event later than 5 business days after the date it received notice of the ruling.

(ii) State the reason(s) why the ruling is in error and the potential harm that may be caused if immediate review is not granted.

(d) *Own motion review.* (1) The Administrator has discretion to initiate the CMS reviewing official procedure, on his or her own motion, of an intermediary hearing officer decision (regardless of whether the decision was favorable or unfavorable to the provider) or other reviewable action.

(2) In order to execise this authority, the designated CMS reviewing official must, no later than 60 days after the

date the Office of Hearings received the intermediary hearing officer decision, notify the parties and the intermediary that he or she reviews the intermediary hearing officer decision or other reviewable action.

(3) In the notice, the designated CMS reviewing officer identifies with particularity the issues that are to be reviewed, and gives the parties (see § 405.1815) a reasonable period to comment on the issues through a written submission complying with paragraph (c)(2) of this section.

(e) *Review procedure.* (1) In reviewing an intermediary hearing officer decision specified in paragraph (b)(2) of this section, the CMS reviewing official must:

(i) Comply with all applicable law, regulations, and CMS Rulings (see § 401.108 of this chapter), and afford great weight to other interpretive and procedural rules and general statements of policy;

(ii) Subject to paragraph (e)(1)(iii) of this section, limit the review to the record of the proceedings before the intermediary hearing officer(s) (see § 405.1827) and any written submissions by the parties under paragraphs (c)(2) or (d) of this section; and

(iii) Consider additional, extra-record evidence only if he or she determines that the evidence was improperly excluded from the intermediary hearing (see § 405.1823).

(2) Review of an intermediary decision specified in paragraph (b)(2) of this section is limited to a hearing on the written record in accordance with paragraph (e)(1)(ii) of this section unless the CMS reviewing official determines that:

(i) Additional, extra-record evidence may be considered in accordance with paragraph (e)(1)(iii) of this section;

(ii) An oral hearing is necessary for consideration of the extra-record evidence; and

(iii) The matter must not be remanded to the intermediary hearing officer(s) in accordance with paragraph (f)(2) of this section.

(3) Upon completion of the review of an intermediary decision specified in paragraph (b)(2) of this section, the CMS reviewing official issues a written decision that affirms, reverses, modifies, or remands the intermediary hearing officer decision. A copy of the decision must be mailed promptly to each party, to the intermediary, and to CMS's Office of Hearings.

(f) *Effect of a decision; remand.* (1) A decision of affirmation, reversal, or modification by the CMS reviewing official is final and binding on each party and the intermediary. No further review or appeal of a decision is available, but the decision may be reopened by a CMS reviewing official in accordance with §§ 405.1885 through 405.1889. Decisions of a CMS reviewing official are subject to the provisions of § 405.1803(d). A decision by a CMS reviewing official remanding an appeal to the intermediary hearing officer(s) for further proceedings under paragraph (f)(2) of this section is not a final decision.

(2) A remand to the intermediary hearing officer(s) by the CMS reviewing official must—

(i) Vacate the intermediary hearing officer decision;

(ii) Be governed by the same criteria that apply to remands by the Administrator to the Board under § 405.1875(f)(2), and require the intermediary hearing officer(s) to take specific actions on remand; and

(iii) Result in the intermediary hearing officer(s) taking the actions required on remand and issuing a new intermediary hearing decision in accordance with § 405.1831 and § 405.1833.

14. Section 405.1835 is revised to read as follows:

§ 405.1835 Right to Board hearing; contents of, and adding issues to, hearing request.

(a) *Criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period, only if—

(1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either:

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Self-disallowing the item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

(2) The amount in controversy (as determined in accordance with § 405.1839) is $10,000 or more; and

(3) 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—

(i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; or

(ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped ''Received'' unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

(b) *Contents of request for a Board hearing.* The provider's request for a Board hearing must be submitted in writing to the Board, and the request must include:

(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the intermediary or Secretary determination under appeal.

(2) An explanation (for each specific item at issue, see § 405.1835(a)(1)) of the provider's dissatisfaction with the intermediary or Secretary determination under appeal, including an account of:

(i) Why the provider believes Medicare payment is incorrect for each disputed item.

(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 the intermediary 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 (2) of this section.

(c) *Adding issues to the hearing request.* After filing a hearing request in accordance with paragraphs (a) and (b) 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) A request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.

(2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.

(3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section or, for a request to add issue(s) following a reopening conducted in accordance with and within the period specified in § 405.1885(c)(1).

15. Section 405.1836 is added to read as follows:

§ 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) must be dismissed by the Board, except 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 can not reasonably be expected to file timely due to extraordinary circumstances beyond its control such as 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).

(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 intermediary 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 mail 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 (see § 405.1840(c)). A copy of the Board's Dismissal Decision must be mailed promptly to each party to the appeal (see § 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), paragraph (e), and paragraph (f) no later than 60 days after the date of receipt by the provider of the Board's decision. 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. A Board decision under paragraph (e)(1) of this section that is otherwise final and binding may be reopened by the Board in accordance with § 405.1885 through § 405.1889.

(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).

(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.

16. Section 405.1837 is revised to read as follows:

§ 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, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination for the period, only if—

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a), except for the $10,000 amount in controversy requirement under § 405.1835(a)(2);

(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.

(b) *Usage and filing of group appeals.* (1) *Mandatory use of group appeals.* Two or more providers under common ownership or control must bring a group appeal before the Board in accordance with this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and for which the amount in controversy is $50,000 or more in the aggregate. Any commonly owned or controlled provider may not appeal to the Board any common issue in a single provider appeal brought under § 405.1835.

(2) *Optional use of group appeals.* Two or more providers not under common ownership or control may bring a group appeal before the Board under this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under § 405.1835.

(3) *Initiating a group appeal.* A provider that is required to bring a group appeal under paragraph (b)(1) of this section must submit, either alone or with other commonly owned or operated providers, a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section. Any group appeal filed by a single provider must be joined by related providers on common issues in accordance with paragraphs (b)(1) and (e) of this section. Providers that have the option of bringing a group appeal under paragraph (b)(2) of this section may submit—

(i) Initially a written request for a Board hearing as a group appeal in accordance with paragraph (c) of this section; or

(ii) A request to the Board in accordance with paragraph (e)(4) of this section that a specific matter at issue in a single provider appeal, filed previously under § 405.1835, be transferred from the single appeal to a group appeal.

(c) *Contents of request for a group appeal.* The request by a provider (or providers) for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include—

(1) A demonstration that the request satisfies—

(i) All of the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section; or

(ii) At least the requirements for a Board hearing as a group appeal under paragraph (a)(1) of this section, if the request is submitted in accordance with paragraph (c)(4)(ii) of this section;

(2) An explanation (for each specific cost at issue, see § 405.1835(a)(1)) of each provider's dissatisfaction with its intermediary or Secretary determination under appeal, including an account of—

(i) Why the provider believes Medicare payment is incorrect for each disputed cost;

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed cost; and

(iii) If the provider self-disallows a specific cost, a description of the nature and amount of each self-disallowed cost and the reimbursement sought for each cost.

(3) A copy of each intermediary or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and

(4) A statement representing that either—

(i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and the Board can proceed to make jurisdictional findings in accordance with § 405.1840; or

(ii) The Board must defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

(d) *Board's preliminary response to group appeal hearing requests.* (1) Upon receipt of a group appeal hearing request, the Board must take any necessary ministerial steps.

(2) The steps, include, for example—

(i) Acknowledging the request;

(ii) Assigning a case number to the appeal; or

(iii) If applicable, transferring a specific matter at issue from a single provider appeal filed under § 405.1835 to a group appeal filed under this section.

(3) For group appeal hearing requests submitted in accordance with paragraph (c)(4)(i) of this section, the Board must make jurisdictional findings in accordance with § 405.1840 before conducting any further proceedings in the appeal under paragraph (e)(3) of this section.

(4) For hearing requests submitted in accordance with paragraph (c)(4)(ii) of this section, the Board may not make jurisdictional findings under § 405.1840 until the providers request the findings under paragraph (e)(2) of this section.

(e) *Group appeal procedures pending full formation of the group and issuance of a Board decision.* (1) A provider (or providers) may file a group appeal hearing request with the Board under this section before each provider member of the group identifies or complies with paragraphs (a)(1) and (a)(2) of this section, or before the group satisfies the $50,000 amount in controversy requirement under paragraph (a)(3) of this section. Proceedings before the Board in any partially formed group appeal are subject to the provisions of paragraphs (e)(2), (e)(3), and (e)(4) of this section.

(2) For group appeal hearing requests submitted in accordance with paragraph (c)(4)(ii) of this section, the Board may not make jurisdictional findings under § 405.1840 until the providers request the findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request and the Board can proceed to make jurisdictional findings. The providers must include with the notice any additional information or documentary evidence that is required for group appeal hearing requests under paragraph (c) of this section, but was not previously submitted by the group members (see § 405.1837(c)(1)(ii)). After receiving the notice from the providers, the Board must make jurisdictional findings in accordance with § 405.1840.

(3) If the Board finds jurisdiction to conduct a hearing as a group appeal under this section, the Board then takes any further actions in the appeal it finds to be appropriate under this subpart (see § 405.1840(a)). The Board may take further actions even though the providers in the appeal may wish to add other providers to the group in accordance with paragraph (e)(4) of this section, but the Board must make separate jurisdictional findings for each cost reporting period added subsequently to the group appeal (see § 405.1837(a) and § 405.1839(b)).

(4) A provider may submit a request to the Board to join a group appeal anytime before the Board issues one of the decisions specified in § 405.1875(a)(2). By submitting a request, the provider agrees that, if the request is granted, the provider is bound by the Board's actions and decision in the appeal.

(5) The Board must grant any request that is unopposed by the group members, received by the Board before the date of issuance of one of the decisions specified in § 405.1875(a)(2), and otherwise complies with this section.

(6) If the Board denies a request, the Board's action is without prejudice to any separate appeal the provider may bring in accordance with § 405.1811, § 405.1835, or this section.

(7) For purposes of determining timeliness for any separate appeal, the period from the date of receipt of the provider's original hearing request through the date of receipt by the provider of the Board's denial of the provider's request to join the group appeal must be excluded from the applicable 180-day period for filing a separate appeal (see § 405.1835(a)(3)) and from the 60-day period for adding issues to any single provider appeal (see § 405.1835(c)(3)).

(f) *Limitations on group appeals.* (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may not add other questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (see § 405.1837(a)(2) and § 405.1837(g)).

(2) The Board may not consider, in one group appeal, more than one question of fact or of interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840:

(i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider.

(ii) Where the appeal is found to involve more than one factual or legal question common to each provider, assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.

(g) *Issues not common to the group appeal.* A provider involved in a group appeal that also wishes to appeal a specific matter that does not raise a factual or legal question common to each of the other providers in the group must file a separate request for a single provider hearing in accordance with § 405.1811 or § 405.1835 or file a separate request for a hearing as part of a different group appeal under this section, as applicable.

17. Section 405.1839 is revised to read as follows:

§ 405.1839 Amount in controversy.

(a) *Single provider appeals.* (1) In order to satisfy the amount in controversy requirement under § 405.1811(a)(2) for an intermediary hearing or the amount in controversy requirement under § 405.1835(a)(2) for a Board hearing for a single provider, the provider must demonstrate that if its appeal were successful, the provider's total program reimbursement for each cost reporting period under appeal increases by at least $1,000 but by less than $10,000 for an intermediary hearing, or by at least $10,000 for a Board hearing, as applicable.

(2) *Aggregation of claims.* For purposes of satisfying the applicable amount in controversy requirement for a single provider appeal to the intermediary or the Board, the provider may aggregate claims for additional program payment for more than one specific matter at issue, provided each specific claim and issue is for the same cost reporting period. Aggregation of claims from more than one cost reporting period to meet the applicable amount in controversy requirement is prohibited, even if a specific claim or issue recurs in the appeal for multiple cost years.

(b) *Group appeals.* (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal increases, in the aggregate, by at least $50,000.

(2) *Aggregation of claims.* For purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues. A group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (see § 405.1837(a)(2)). However, the single issue that is common to each provider may exist over different cost reporting periods. For purposes of satisfying the amount in controversy requirement, a provider may appeal multiple cost reporting periods and different providers in the group may appeal different cost reporting periods.

(c) *Limitations on change in Medicare reimbursement.*

(1) In order to satisfy the applicable amount in controversy requirement for a single provider appeal or a group appeal, an appeal favorable to the provider(s) on all specific matters at issue in the appeal increases program reimbursement for the provider(s) in the cost reporting period(s) at issue by an amount that equals or exceeds the applicable amount in controversy threshold.

(2) The applicable amount in controversy requirement is not satisfied if the result of a favorable appeal decreases program reimbursement for the provider(s) in the cost reporting year(s) at issue in the appeal.

(3) Any effects that a favorable appeal might have on program reimbursement for the provider(s) in cost reporting period(s) not at issue in the appeal have no bearing on whether the amount in controversy requirement is satisfied for the cost year(s) at issue in the appeal.

18. A new § 405.1840 is added to read as follows:

§ 405.1840 Board jurisdiction.

(a) *General rules.* (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.

(2) The Board must make a preliminary determination of the scope of its jurisdiction, if any, over the matters at issue in the appeal, and notify the parties of its specific jurisdictional findings, before conducting any of the following proceedings:

(i) Determining its authority to decide a legal question relevant to a matter at issue (see § 405.1842 of this part); permitting discovery (see § 405.1853).

(ii) Issuing a subpoena (see § 405.1857).

(iii) Conducting a hearing (see § 405.1845 of this part).

(3) The Board may revise a preliminary jurisdictional finding at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised findings. Under paragraph (c)(1) of this section, each expedited judicial review decision (see § 405.1842 of this part) and hearing decision (see § 405.1871 of this part) by the Board must include a jurisdictional finding for each specific matter at issue in the appeal.

(4) If the Board determines it lacks jurisdiction over every specific matter at issue in the appeal, the Board must issue a Dismissal Decision under paragraph (c)(2) of this section.

(5) Jurisdictional findings and Dismissal Decisions by the Board under paragraphs (c)(1) and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.

(b) *Criteria.* The Board's jurisdiction to grant a hearing must be determined separately for each specific matter at issue in each intermediary or Secretary determination for each cost reporting period under appeal. The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this part or as part of a group appeal under § 405.1837 of this part, as applicable. Certain matters at issue are removed from the Board's jurisdiction; these matters include, but are not necessarily limited to, the following:

(1) A finding in an intermediary determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act, and § 411.15 of this chapter; review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act, and of subparts G and H of part 405 and subpart B of part 473, as applicable.

(2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in § 405.1804 of this part.

(3) Any self-disallowed cost, except as permitted in § 405.1835(a)(1)(ii) and § 405.1837(a)(1) of this part.

(c) *Board's Jurisdictional Findings and Jurisdictional Dismissal Decisions.* (1) In issuing an Expedited Judicial Review Decision under § 405.1842 of this part or a Hearing Decision under § 405.1871 of this part, as applicable, the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue in each intermediary or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.

(2) Except as provided in § 405.1836(e)(1) and § 405.1842(g)(2)(i) of this part, where the Board determines it lacks jurisdiction to grant a hearing for every specific matter at issue in an appeal, it must issue a Dismissal Decision dismissing the appeal for lack of Board jurisdiction. The decision by the Board must include 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. A copy of the Board's decision

must be mailed promptly to each party to the appeal (see § 405.1843 of this part).

(3) A Dismissal Decision by the Board under paragraph (c)(2) 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), (e), and (f) no later than 60 days after the date of receipt by the provider of the Board's decision. The 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 that period. A final Board decision under paragraphs (c)(2) and (c)(3) of this section, may be reopened by the Board in accordance with §§ 405.1885 through 405.1889 of this part.

(d) *Administrator and judicial review*. Any finding by the Board as to whether it has jurisdiction to grant a hearing on a specific matter at issue in an appeal is not subject to further administrative and judicial review, except as provided in this paragraph. The Board's jurisdictional findings as to specific matters at issue in an appeal may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2) of this part, or during the course of judicial review of a final agency decision as described in § 405.1877(a) of this part, as applicable.

§ 405.1841 [Removed]

19. Section 405.1841 is removed.

20. Section 405.1842 is revised to read as follows:

§ 405.1842 Expedited judicial review.

(a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek expedited judicial review (EJR) of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (see § 405.1840 of this part), and the Board determines it lacks the authority to decide the legal question (see § 405.1867 of this part, which describes the scope of Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. Each EJR Decision by the Board must include a specific jurisdictional finding on the matter(s) at issue, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

(3) The Administrator may review the Board's jurisdictional finding, but not the Board's authority determination.

(4) The provider has a right to seek EJR of the legal question under section 1878(f)(1) of the Act only:

(i) If the final EJR Decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue and a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) If the Board fails to make a determination of its authority to decide the legal question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete.

(b) *Overview*—(1) *Prerequisite of Board jurisdiction*. The Board or the Administrator must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.

(2) *Initiating EJR procedures.* A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal, or the Board on its own motion may consider whether to grant EJR of a specific matter or matters under appeal. Under paragraph (c) of this section, the Board may initiate own motion consideration of its authority to decide a legal question only if the Board makes a preliminary finding that it has jurisdiction over the specific matter at issue to which the legal question is relevant. Under paragraphs (d) and (e) of this section, a provider may request a determination of the Board's authority to decide a legal question, but the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.

(c) *Board's own motion consideration*. (1) If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, it may then consider on its own motion, whether it lacks the authority to decide a legal question relevant to the matter at issue.

(2) The Board must initiate its own motion consideration by issuing a written notice to each of the parties to the appeal (see § 405.1843 of this part). The notice must:

(i) Identify each specific matter at issue for which the Board has made a finding that it has jurisdiction under § 405.1840(a) of this part, and for each specific matter, identify each relevant statutory provision, regulation, or CMS Ruling.

(ii) Specify a reasonable period of time for the parties to respond in writing.

(3) After considering any written responses made by the parties to its notice of own motion consideration, the Board must determine whether it has sufficient information to issue an EJR Decision for each specific matter and legal question included in the notice. If necessary, the Board may request additional information regarding its jurisdiction or authority from a party (or parties), and the Board must give any other party a reasonable opportunity to comment on any additional submission. Once the Board determines it needs no further information from the parties (or that any information has not been rendered timely), it must issue an EJR Decision in accordance with paragraph (f) of this section.

(d) *Provider requests*. A provider (or, in the case of a group appeal, the group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal. A provider must submit a request in writing to the Board and to each party to the appeal (see § 405.1843 of this part), and the request must include—

(1) For each specific matter and question included in the request, an explanation of why the provider believes the Board has jurisdiction under § 405.1840 of this part over each matter at issue and no authority to decide each relevant legal question; and

(2) Any documentary evidence the provider believes supports the request.

(e) *Board action on provider requests*. (1) If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840(a) of this part, then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue. The Board is required to make a determination of its authority to decide the legal question raised in a review request under paragraph (d)(1) of this section, by issuing an EJR Decision no later than 30 days after receiving a complete provider request as defined in paragraph (e)(2) of this section.

(2) *Requirements of a complete provider request*. A complete provider request for EJR consists of:

(i) A request for an EJR Decision by the provider(s).

(ii) All of the information and documents found necessary by the Board for issuing a decision in accordance with paragraph (f) of this section.

(3) *Board's response to provider requests.* After receiving a provider request for an EJR Decision, the Board must review the request, along with any responses to the request submitted by other parties to the appeal (see § 405.1843 of this part). The Board must respond to the provider(s) as follows:

(i) Upon receiving a complete provider request, issue an EJR Decision in accordance with paragraph (f) of this section no later than 30 days after receipt of the complete provider request. If the Board does not issue a decision within that 30-day period, the provider has a right to file a complaint in Federal district court in order to obtain EJR over the specific matter(s) at issue.

(ii) If the provider has not submitted a complete request, issue a written notice to the provider describing in detail the further information that the provider must submit in order to complete the request.

(f) *Board's decision on EJR: criteria for granting EJR.* Subject to paragraph (h)(3) of this section, the Board is required to issue an EJR decision following either the completion of the Board's own motion consideration under paragraph (c) or a notice issued by the Board in accordance with paragraph (e)(3)(i) of this section.

(1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:

(i) The Board determines that it has jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this part.

(ii) The Board determines it lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge to the constitutionality of a provision of a statute, or the substantive and procedural validity of a regulation or CMS Ruling.

(2) Must deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if any of the following conditions are satisfied:

(i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840; or

(ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is not a challenge to the constitutionality of a provision of a statute, and is not a challenge to the substantive and/or procedural validity of a regulation or CMS Ruling.

(iii) The Board does not have sufficient information to determine whether the criteria specified in paragraph (f)(i) or (f)(ii) of this section are met.

(3) A copy of the Board's decision must be sent promptly to each party to the Board appeal (see § 405.1843 of this part) and to the Office of the Attorney Advisor.

(g) *Further review after the Board issues an EJR Decision*— (1) *General rules.* (i) Under § 405.1875(a)(2)(iii) of this part, the Administrator may review, on his or her own motion, or at the request of a party, the jurisdictional component only of the Board's EJR Decision.

(ii) Any review by the Administrator is limited to the question of whether there is Board jurisdiction over the specific matter at issue; the Administrator may not review the Board's determination of its authority to decide the legal question.

(iii) An EJR Decision by the Board becomes final and binding on the parties unless the decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(iii) of this part, (e), and (f) of this section no later than 60 days after the date of receipt by the provider of the Board's decision.

(iv) A Board decision is inoperative during the 60-day period for review by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision within that period.

(v) Any right of the provider to obtain EJR from a Federal district court is specified at paragraphs (g)(2) and (g)(3) of this section (where the Board issues a timely EJR Decision) and paragraph (g)(4) of this section (in the absence of a timely Board decision).

(vi) A final Board decision under paragraph (f) of this section, and a final Administrator decision made upon review of final Board decision (see § 405.1875(a)(2) and (e) of this part) may be reopened in accordance with §§ 405.1885 through 405.1889 of this part.

(2) *Board grants EJR.* If the Board grants EJR, the provider may file a complaint in a Federal district court in order to obtain expedited judicial review of the legal question unless the Administrator issues, no later than 60 days after the date of receipt by the provider of the Board's decision granting EJR, a decision finding that the Board has no jurisdiction over the matter at issue, thereby reversing the Board's decision (see § 405.1877(a)(3) and (b)(3) of this part).

(3) *Board denies EJR.* If the Board's decision denies EJR because the Board finds that it has the authority to decide the legal question relevant to the matter at issue, the Administrator may not review the Board's authority determination and the provider has no right to obtain expedited judicial review. If the Board denies EJR based on a finding that it lacks jurisdiction over the specific matter, the provider has no right to obtain EJR unless the Administrator issues timely a final decision reversing the Board and finding the Board has jurisdiction over the matter at issue and the Board subsequently issues on remand from the Administrator an EJR decision granting EJR on the basis that it lacks the authority to decide the legal question.

(4) *No timely EJR Decision.* The Board must issue an EJR Decision no later than 30 days after the date of a written notice under paragraph (e)(3)(i) of this section, when the provider submits a complete request for EJR. If the Board does not issue an EJR Decision within a 30-day period, the provider(s) has a right to seek expedited judicial review under section 1878(f)(1) of the Act.

(h) *Effect of final EJR Decisions and lawsuits on further Board proceedings*— *(1) Final decisions granting EJR.* If the final decision of the Board or the Administrator, as applicable (see § 405.1842(g)(1) and § 405.1875(e)(4) of this part), grants EJR, the Board may not conduct any further proceedings on the legal question. The Board must dismiss:

(i) The specific matter at issue from the appeal.

(ii) The entire appeal if there are no other matters at issue that are within the Board's jurisdiction and can be fully decided by the Board.

(2) *Final decisions denying EJR.* If the final decision:

(i) Of the Board denies EJR solely on the basis that the Board determines it has the authority to decide the legal question relevant to the specific matter at issue, the Board must conduct further proceedings on the legal question and issue a decision on the matter at issue in accordance with this subpart. *Exception*: If the provider(s) files a lawsuit pertaining to the legal question, and for a period that is covered by the Board's decision denying EJR, the Board may not conduct any further proceedings under this subpart on the legal question or the matter at issue before the lawsuit is finally resolved.

(ii) Of the Board or the Administrator denies EJR on the basis that the Board

lacks jurisdiction over the specific matter at issue, the Board or the Administrator, must, as applicable, dismiss the specific matter at issue from the appeal, or dismiss the appeal entirely if there are no other matters at issue that are within the Board's jurisdiction and can be fully decided by the Board. If only the specific matter(s) is dismissed from the appeal, judicial review may be had only after a final decision on the appeal is made by the Board or Administrator, as applicable (see § 405.1840(d), § 405.1877(a) of this part). If the Board or the Administrator, as applicable, dismisses the appeal entirely, the decision is subject to judicial review under § 405.1877(a) of this part.

(3) *Provider lawsuits.* (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or otherwise) pertaining to a legal question that is allegedly relevant to a specific matter at issue for a cost year in a Board appeal and not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

(ii) If the lawsuit is filed after a final EJR Decision by the Board or the Administrator, as applicable (see § 405.1842(g)(1) and § 405.1875(e)(4)), on the legal question, the Board must carry out the applicable provisions of paragraphs (h)(1) and (h)(2) of this section in any pending Board appeal on the specific matter at issue.

(iii) If the lawsuit is filed before a final EJR Decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved.

21. Section § 405.1843 is revised to read as follows:

§ 405.1843 Parties to proceedings in a Board appeal.

(a) When a provider files a request for a hearing before the Board in accordance with § 405.1835 or § 405.1837, the parties to all proceedings in the Board appeal include the provider, an intermediary, and, where applicable, any other entity found by the intermediary to be a related organization of the provider under § 413.17 of this chapter.

(b) Neither the Secretary nor CMS may be made a party to proceedings in a Board appeal. The Board may call as a witness any employee or officer of Heath and Human Services or CMS having personal knowledge of the facts and the issues in controversy in an appeal.

(c) An intermediary may designate a representative from the Secretary or CMS, who may be an attorney, to represent the intermediary in proceedings before the Board.

(d) Although CMS is not a party to proceedings in a Board appeal, there may be instances where CMS determines that the administrative policy implications of a case are substantial enough to warrant comment from CMS (see § 405.1863). In these cases, CMS may file *amicus curiae* (friend of the court) briefing papers with the Board in accordance with a schedule to be determined by the Board. CMS must promptly mail copies of any documents filed with the Board to each party to the appeal.

22. Section 405.1845 is amended by—

A. Revising the section heading.

B. Revising paragraph (c).

C. Revising paragraph (d).

D. Revising paragraph (e).

E. Adding paragraph (f).

F. Adding Paragraph (g).

The revisions and additions read as follows:

§ 405.1845 Composition of Board; hearings, decisions, and remands.

* * * * *

(c) *Composition of Board.* The Secretary designates one member of the Board as Chairperson. The Chairperson coordinates and directs the administrative activities of the Board and the conduct of proceedings before the Board. CMS provides administrative support for the Board. Under the direction of the Chairperson, the Board is solely responsible for the content of its decisions.

(d) *Quorum.* (1) The Board must have a quorum in order to issue one of the decisions specified as final, or deemed final by the Administrator, under § 405.1875(a)(2), but a quorum is not required for other Board actions.

(2) Three Board members, at least one of who is representative of providers, are required in order to constitute a quorum.

(3) The opinion of the majority of those Board members issuing a decision specified as final, or deemed as final by the Administrator, under § 405.1875(a)(2) constitutes the Board's decision.

(e) *Hearings.* The Board may conduct a hearing and issue a Hearing Decision (see § 405.1871) on a specific matter at issue in an appeal, provided it finds jurisdiction over the matter at issue in accordance with § 405.1840 of this part and determines it has the legal authority to fully resolve the issue (see § 405.1867 of this part).

(f) *Oral Hearings.* (1) In accordance with paragraph (d) of this section, the Board does not need a quorum in order to hold an oral hearing (see § 405.1851 of this part). The Chairperson of the Board may designate one or more Board members to conduct an oral hearing (where less than a quorum conducts the hearing). Because the presence of all Board members is not required at an oral hearing, the Board, at its discretion, may hold more than one oral hearing at a time.

(2) *Waiver of oral hearings.* With the intermediary's agreement and the Board's approval, the provider (or, in the case of group appeals, the group of providers) and any related organizations (see § 405.1836 of this part) may waive any right to an oral hearing and stipulate that the Board may issue a Hearing Decision on the written record. An on-the-written-record hearing consists of all the evidence and written argument or comments must be submitted to the Board and included in the record (see § 405.1865 of this part).

(3) *Hearing decisions.* The Board's Hearing Decision must be based on the transcript of any oral hearing before the Board, any matter admitted into evidence at a hearing or deemed admissible evidence for the record (see § 405.1855 of this part), and any written argument or comments timely submitted to the Board (see § 405.1865 of this part).

(g) *Remands.* (1) Except as provided in paragraph (g)(3) of this section, a Board remand order may be reviewed solely during the course of Administrator review of one of the Board decisions specified in § 405.1875(a)(2) of this part), or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this part, as applicable.

(2) The Board may order a remand requiring specific actions of a party to the appeal. In ordering a remand, the Board must—

(i) Specify any actions required of the party and explain the factual and legal basis for ordering a remand;

(ii) Be in writing;

(iii) Be mailed promptly to the parties and any affected non-party, such as CMS, to the appeal.

(3) A Board remand order is not subject to immediate Administrator review unless the Administrator determines that the remand order might otherwise evade his or her review. (see § 405.1875(a)(2)(iv)).

23. Section 405.1853 is revised to read as follows:

§ 405.1853 Board proceedings prior to any hearing; discovery.

(a) *Preliminary narrowing of the issues.* Upon receiving notification that

a request for a Board hearing is submitted, the intermediary must:

(1) Promptly review both the materials submitted with the provider hearing request, and the information underlying each intermediary or Secretary determination for each cost reporting period under appeal.

(2) Expeditiously attempt to join with the provider in resolving specific factual or legal issues and submitting to the Board written stipulations setting forth the specific issues that remain for Board resolution based on the review.

(3) Ensure that the evidence it considered in making its determination, or, where applicable, the evidence the Secretary considered in making his or her determination, is included in the record.

(b) *Position papers.* (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines when the provider(s) and the intermediary must submit position papers to the Board.

(2) The Board may extend the deadline for submitting a position paper for good cause shown. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (see § 405.1840 of this part), and the merits of the provider's Medicare payment claims for each remaining issue.

(3) Any supporting exhibits regarding Board jurisdiction must accompany the position paper; exhibits regarding the merits of the provider's Medicare payment claims may be submitted later in a time frame to be decided by the Board.

(c) *Initial status conference.* (1) Upon review of the parties' position papers, one or more members of the Board may conduct an initial status conference. An initial status conference may be conducted in person or telephonically, at the discretion of the Board.

(2) The Board may use the status conference to discuss any of the following:

(i) Simplification of the issues.

(ii) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement.

(iii) Stipulations and admissions of fact or as to the content and authenticity of documents.

(iv) If the parties can agree to submission of the case on a stipulated record.

(v) If a party chooses to waive appearance at an oral hearing and to submit only documentary evidence (the admissibility of which is subject to objection from other parties) and written argument.

(vi) Limitation of the number of witnesses.

(vii) Scheduling dates for the exchange of witness lists and of proposed exhibits.

(viii) Discovery as permitted under this section.

(ix) The time and place for the hearing.

(x) Potential settlement of some or all of the issues.

(xi) Other matters that the Board deems necessary and appropriate. The Board may issue any orders at the conference found necessary and appropriate to narrow the issues further and expedite further proceedings in the appeal.

(3) After the status conference, the Board may:

(i) Issue in writing a report and order specifying what transpired and formalizing any orders issued at the conference.

(ii) Require the parties to submit (jointly or otherwise) a proposed report and order, in order to facilitate issuance of a final report and order.

(d) *Further status conferences.* Upon a party's request, or on its own motion, the Board may conduct further status conferences where it finds the proceedings necessary and appropriate.

(e) *Discovery*—(1) *General rules.* (i) Discovery is limited in Board proceedings.

(ii) The Board may permit discovery of a matter that is relevant to the specific subject matter of the Board hearing, provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate.

(iii) Any discovery initiated by a party must comply with all requirements and limitations of this section, along with any further requirements or limitations ordered by the Board.

(iv) The applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance for any discovery that is permitted under this section or by Board order.

(2) *Limitations on discovery.* Any discovery before the Board is limited as follows:

(i) A party may request of another party or a non-party the reasonable production of documents for inspection and copying, or may propound a reasonable number of interrogatories.

(ii) A party may not take the deposition, upon oral or written examination, of another party or a non-party, unless the proposed deponent agrees to the deposition or the Board finds that the proposed deposition is necessary and appropriate under the criteria set forth in Fed. R. Civ. P. 26 and 32 in order to secure the deponent's testimony for a Board hearing.

(iii) A party may not request admissions or take any other form of discovery not permitted under this section.

(3) *Time limits.* (i) A party's discovery request is timely if the date of receipt of a request by another party or non-party, as applicable, is no later than 90 days before the scheduled starting date of the Board hearing, unless the Board extends the time upon request of the party and upon a showing of good cause.

(ii) Discovery may not be conducted by a party any later than 45 days before the scheduled starting date of the Board hearing unless the Board finds, at the request of the party, good cause to extend the period for discovery.

(iii) Before ruling on a request to extend the time for requesting discovery or for conducting discovery, the Board must give the other parties to the appeal and any non-party subject to a discovery request a reasonable period to respond to the extension request.

(iv) The Board may extend the time in which to request discovery or conduct discovery only if the requesting party establishes that it was not dilatory or otherwise at fault in not meeting the original discovery deadline.

(v) If the Board grants the extension request, it must impose a new discovery deadline and, if necessary, reschedule the hearing date so that all discovery ends no later than 45 days before the hearing.

(4) *Rights of non-parties.* If a discovery request is made of a non-party to the Board appeal, the non-party (including HHS and CMS) has the same rights as any party has in responding to a discovery request.

(5) *Motions to compel or for protective order.*

(i) Each party is required to make a good faith effort to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a non-party.

(ii) A party may submit to the Board a motion to compel discovery that is permitted under this section or any Board order, and a party or non-party may submit a motion for a protective order regarding any discovery request to the Board.

(iii) Any motion to compel or for protective order must include a self-sworn declaration describing the movant's efforts to resolve or narrow the discovery dispute.

(iv) The declaration must be included with any response to a motion to compel or for protective order.

(v) The Board must decide any motion in accordance with this section and any prior discovery ruling.

(vi) The Board must issue and mail to each party and any affected non-party a discovery ruling that grants or denies the motion to compel or for protective order in whole or in part; if applicable, the discovery ruling must specifically identify any part of the disputed discovery request upheld and any part rejected, and impose any limits on discovery the Board finds necessary and appropriate.

(6) *Reviewability of discovery and disclosure rulings*—

(i) *General rule.* A Board discovery ruling, or a Board disclosure ruling such as one issued at a hearing is not subject to immediate review by the Administrator (see § 405.1875(a)(3)). The ruling may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2), or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3), as applicable.

(ii) *Exception.* To the extent a ruling authorizes discovery or disclosure of a matter for which an objection based on privilege, or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before the Board, that portion of the discovery or disclosure ruling may be reviewed immediately by the Administrator in accordance with § 405.1875(a)(3)(i). Upon notice to the Board that a party or non-party, as applicable, intends to seek Administrator review of the ruling, the Board must stay all proceedings affected by the ruling. The Board determines the length of the stay under the circumstances of a given case, but in no event must the length of the stay be less than 15 days after the day on which the Board received notice of the party or non-party's intent to seek Administrator review. If the Administrator grants a request for review, or takes own motion review, of the a ruling, the ruling is stayed until the time the Administrator issues a written decision that affirms, reverses, modifies, or remands the Board's ruling. If the Administrator does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the ruling stands.

24. Section 405.1857 is revised to read as follows:

§ 405.1857 Subpoenas.

(a) *Time limits.* (1) The Board may issue a subpoena:

(i) To a party to a Board appeal or to a non-party requiring the attendance and testimony of witnesses or the production of documents for inspection and copying, provided the Board makes a preliminary finding of its jurisdiction over the matters at issue in accordance with § 405.1840(a) of this part.

(ii) At the request of a party for purposes of discovery (see § 405.1853 of this part) or an oral hearing (see § 405.1845 of this part).

(iii) On its own motion solely for purposes of a hearing.

(2) The date of receipt by the Board of a party's subpoena request may not be any later than:

(i) For subpoenas requested for purposes of discovery, 90 days before the scheduled starting date of the Board hearing; and

(ii) For subpoenas requested for purposes of an oral hearing, 45 days before the scheduled starting date of the Board hearing.

(3) The Board may not issue a subpoena any later than:

(i) For purposes of a discovery subpoena, 75 days before the scheduled starting date of the Board hearing; and

(ii) For purposes of a hearing subpoena, whether issued at a party's request or on the Board's own motion, 30 days before the scheduled starting date of the Board hearing.

(4) The Board may extend for good cause the deadlines specified in paragraphs (a)(2) and (a)(3) of this section provided the Board:

(i) Gives each party to the appeal and any non-party subject to a subpoena request or subpoena a reasonable period of time to comment on any proposed extension.

(ii) Finds that the party requesting the extension, where applicable, was not dilatory or otherwise at fault in not meeting the original subpoena deadlines.

(iii) Imposes new deadlines and, if necessary, reschedules the hearing date so that all subpoena requests are submitted and all subpoenas issued within the time periods specified in paragraphs (a)(2) and (a)(3) of this section.

(b) *Criteria*—(1) *Discovery subpoenas.* The Board may issue a subpoena for purposes of discovery if:

(i) The subpoena was requested in accordance with the requirements of paragraph (c)(1) of this section.

(ii) The party's discovery request complies with the applicable provisions of § 405.1853(e) of this part.

(iii) A subpoena is necessary and appropriate to compel a response to the discovery request.

(2) *Hearing subpoenas.* The Board may issue a subpoena for purposes of an oral hearing if:

(i) If applicable, the party's subpoena request meets the requirements of paragraph (c)(1) of this section.

(ii) A subpoena is necessary and appropriate to compel the attendance and testimony of witnesses or the production of documents for inspection or copying, provided the testimony or documents are relevant and material to a matter at issue in the appeal but not unduly repetitious (see § 405.1855 of this part).

(iii) The subpoena does not compel the disclosure of matter that is privileged or otherwise protected from disclosure for reasons such as case preparation, confidentiality, or undue burden.

(iv) The subpoena does not impose undue burden or expense on the party or non-party subject to the subpoena, and is not otherwise unreasonable or inappropriate.

(3) *Guiding principles.* In determining whether to issue, quash, or modify a subpoena under this section, the Board must comply with the applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence for guidance.

(c) *Procedures*—(1) *Subpoena requests.* The requesting party must mail any subpoena request submitted to the Board promptly to the party or non-party subject to the subpoena, and to any other party to the Board appeal. The request must:

(i) Identify with particularity any witnesses (and their addresses, if known) or any documents (and their location, if known) sought by the subpoena, and the means, time, or location for securing any witness testimony or documents.

(ii) Describe specifically, in the case of a hearing subpoena, the facts any witnesses, documents, or tangible materials are expected to establish, and why those facts cannot be established without a subpoena.

(iii) Explain why a subpoena is appropriate under the criteria prescribed in paragraph (b) of this section.

(2) *Contents of subpoenas.* A subpoena issued by the Board, whether on its own motion or at the request of a party, must be in writing and either sent promptly by the Board to the party or non-party subject to the subpoena by certified mail or overnight delivery (and to any other party and affected non-

party to the appeal by regular mail), or hand-delivered. Each subpoena must:

(i) Be issued in the name of the Board, and include the case number and name of the appeal.

(ii) Provide notice that the subpoena is issued in accordance with section 1878(e) of the Act, and § 405.1857 of this part, and that CMS must pay the fees and the mileage of any witnesses, as provided in section 205(d) of the Act.

(iii) If applicable, require named witnesses to attend a particular proceeding at a certain time and location, and to testify on specific subjects.

(iv) If applicable, require the production of specific documents for inspection or copying at a certain time and location.

(3) *Rights of non-parties.* If a non-party to the Board appeal is subject to the subpoena or subpoena request, the non-party (including HHS and CMS) has the same rights as any party has in responding to a subpoena or subpoena request. These rights include, but are not limited to, the right to select and use any attorney or other representative, and to submit responses, objections, motions, or any other pertinent materials to the Board regarding the subpoena or subpoena request.

(4) *Board action on subpoena requests and motions.* After issuing a subpoena or receiving a subpoena request, the Board must:

(i) Give the party or non-party subject to the subpoena or subpoena request a reasonable period of time for the submission of any responses, objections, or motions.

(ii) Consider the subpoena or subpoena request, and any responses, objections, or motions related thereto, under the criteria specified in paragraph (b) of this section.

(iii) Issue in writing and mail promptly to each party and any affected non-party an order granting or denying any motion to quash or modify a subpoena, or granting or denying any subpoena request in whole or in part; and issue, if applicable, an original or modified subpoena in accordance with paragraph (c)(2) of this section.

(d) *Reviewability*—(1) *General rules.* (i) If the Board issues, quashes, or modifies, or refuses to issue, quash, or modify, a subpoena under paragraphs (c)(2) or (c)(4) of this section, the Board's action is not subject to immediate review by the Administrator (see § 405.1875(a)(3) of this part).

(ii) Any Board action may be reviewed solely during the course of Administrator review of one of the Board decisions specified in § 405.1875(a)(2) of this part, or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this part, as applicable.

(2) *Exception.* (i) To the extent a subpoena compels disclosure of a matter for which an objection based on privilege, or other protection from disclosure such as case preparation, confidentiality, or undue burden, was made before the Board, the Administrator may review immediately that portion of the subpoena in accordance with § 405.1875(a)(3)(ii).

(ii) Upon notice to the Board that a party or non-party, as applicable, intends to seek Administrator review of the subpoena, the Board must stay all proceedings affected by the subpoena.

(iii) The Board determines the length of the stay under the circumstances of a given case, but in no event is less than 15 days after the day on which the Board received notice of the party or non-party's intent to seek Administrator review.

(iv) If the Administrator grants a request for review, or takes own motion review, of the subpoena, the subpoena or portion of the subpoena, as applicable, is stayed until the time as the Administrator issues a written decision that affirms, reverses, modifies, or remands the Board's action for the subpoena.

(v) If the Administrator does not grant review or take own motion review within the time allotted for the stay, the stay is lifted and the Board's action stands.

(e) *Enforcement.* (i) If the Board determines, whether on its own motion or at the request of a party, that a party or non-party subject to a subpoena issued under this section has refused to comply with the subpoena, the Board may request the Administrator to seek enforcement of the subpoena in accordance with section 205(e) of the Act, 42 U.S.C. 405(e).

(ii) Any enforcement request by the Board must consist of a written notice to the Administrator describing in detail the Board's findings of noncompliance and its specific request for enforcement, and providing a copy of the subpoena and evidence of its receipt by certified mail by the party or nonparty subject to the subpoena.

(iii) The Board must promptly mail a copy of the notice and related documents to the party or non-party subject to the subpoena, and to any other party and affected non-party to the appeal.

25. Section 405.1865 is revised to read as follows:

§ 405.1865 Record of administrative proceedings.

(a)(1) The Board and, if applicable, the Administrator must maintain a complete record of all proceedings in each appeal.

(2) For proceedings before the Board, the administrative record consists of all evidence, documents and any other tangible materials submitted by the parties to the appeal and by any non-party (see § 405.1853(d) and § 405.1857(c)(3) of this part), along with all Board correspondence, rulings, subpoenas, orders, and decisions.

(3) The term record is intended to encompass both the unappended record and any appendix to the record (see § 405.1865(b) of this part).

(4) The record also includes a complete transcription of the proceedings at any oral hearing before the Board.

(5) A copy of any transcription must be made available to any party upon written request.

(b) Any evidence ruled inadmissible by the Board (see § 405.1855 of this part) and any other submitted matter that the Board declines to consider (whether as untimely or otherwise) must be, to the extent practicable, clearly identified and segregated in an appendix to the record for purposes of any further review (see §§ 405.1875 and 405.1877 of this part).

(c) To the extent applicable, the administrative record also includes all documents (including written submissions) and any other tangible materials to the Administrator by the parties to the appeal or by any non-party (see § 405.1853(d) and § 405.1857(c)(3) of this part), in addition to all correspondence from the Administrator or the Office of the Attorney Advisor and all rulings, orders, and decisions by the Administrator. The provisions of paragraph (b) of this section also pertain to any proceedings before the Administrator, to the extent the Administrator finds evidence inadmissible or declines to consider specific matter (whether as untimely or otherwise).

§ 405.1867 [Amended]

26. Section 405.1867 is amended by:

A. Revising the section heading to read as follows: ''Scope of Board's legal authority.''

B. Revising the introductory clause, in the first sentence to read as follows: ''In exercising its authority to conduct proceedings under this subpart,''.

27. A new § 405.1868 is added to read as follows:

§ 405.1868 Board actions in response to failure to follow Board rules.

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board does not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(c) If an intermediary fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may take action it considers appropriate, such as issuing a written notice to the Administrator describing the intermediary's actions and requesting that the notice be considered in CMS' review of the intermediary's compliance with the contractual requirements of § 421.120, § 421.122, and § 421.124 of this chapter. The Board's authority for the intermediary does not include reversing or modifying the intermediary or Secretary determination for the cost reporting period under appeal, or ruling against the intermediary on a disputed issue of law or fact in the appeal.

(d)(1) If the Board dismisses the appeal with prejudice under this section, it must issue a Dismissal Decision dismissing the appeal. The decision by the Board must be in writing and include an explanation of the reason for the dismissal. A copy of the Board's Dismissal Decision must be mailed promptly to each party to the appeal (see § 405.1843).

(2) A Dismissal Decision by the Board under paragraph (f)(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), paragraphs (e), and (f) of this section no later than 60 days after the date of receipt by the provider of the Board's decision. The Board decision is inoperative during the 60-day period for review by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands the decision within the period. The Board may reopen final Board decision under paragraphs (f)(1) and (f)(2) of this section, in accordance with §§ 405.1885 through 405.1889.

(3) Any action taken by the Board under this section other than dismissal of the appeal is not subject to immediate Administrator review (see § 405.1875(a)(3)) or judicial review (see § 405.1877(a)(3)). A Board action other than dismissal of the appeal may be reviewed solely during the course of Administrator review of one of the Board decisions specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2) or of judicial review of a final agency decision as described in § 405.1877(a), as applicable.

28. Section 405.1869 is revised as follows:

§ 405.1869 Scope of Board's authority in a hearing decision.

(a) If the Board has jurisdiction to conduct a hearing on a specific matter at issue under section 1878(a) or (b) of the Act and § 405.1840, and the legal authority to fully resolve the matter in a hearing decision (see § 405.1842(f)(3), § 405.1867, and § 405.1871), section 1878(d) of the Act, and paragraph (a) of this section, give the Board the power to affirm, modify, or reverse the intermediary's findings on each specific matter at issue in the intermediary determination for the cost reporting period under appeal, and to make additional revisions on specific matters regardless of whether the intermediary considered the matters in issuing the intermediary determination. The Board's power to make additional revisions in a hearing decision does not authorize the Board to consider or decide a specific matter at issue for which it lacks jurisdiction (see § 405.1840(b)) or which was not timely raised in the provider's hearing request. The Board's power under section 1878(d) of the Act and paragraph (a) of this section to make additional revisions is limited to those revisions necessary to resolve fully a specific matter at issue if—

(1) The Board has jurisdiction to grant a hearing on the specific matter at issue under section 1878(a) or (b) of the Act and § 405.1840; and

(2) The specific matter at issue was timely raised in an initial request for a Board hearing filed in accordance with § 405.1835 or § 405.1837, as applicable, or in a timely request to add issues to a single provider appeal submitted in accordance with § 405.1835(c).

(b)(1) If the Board has jurisdiction to conduct a hearing on a specific matter at issue solely under § 405.1840 and § 405.1835 or § 405.1837, as applicable, and the legal authority to fully resolve the matter in a hearing decision (see §§ 405.1842(f)(3), 405.1867, and 405.1871), the Board is authorized to:

(i) Affirm, modify, or reverse the intermediary's or Secretary's findings on each specific matter at issue in the intermediary or Secretary determination under appeal.

(ii) Make additional revisions on each specific matter at issue regardless of whether the intermediary considered these revisions in issuing the intermediary determination under appeal, provided the Board does not consider or decide a specific matter for which it lacks jurisdiction (see § 405.1840(b)) or that was not timely raised in the provider's hearing request.

(2) The Board's authority under this section to make the additional revisions is limited to those revisions necessary to fully resolve a specific matter at issue if:

(i) The Board has jurisdiction to grant a hearing on the specific matter solely under § 405.1840 and § 405.1835 or § 405.1837, as applicable.

(ii) The specific matter at issue was timely raised in the request for a Board hearing filed in accordance with § 405.1835 or § 405.1837, as applicable.

29. Section 405.1871 is revised to read as follows:

§ 405.1871 Board Hearing Decision.

(a)(1) If the Board finds jurisdiction over a specific matter at issue and conducts a hearing on the matter (see § 405.1840(a) and § 405.1845(e)), the Board must issue a Hearing Decision deciding the merits of the specific matter at issue.

(2) A Board Hearing Decision must be in writing and based on the admissible evidence from the Board hearing and other admissible evidence and written argument or comments as may be included in the record and accepted by the Board (see § 405.1845(f)(3) and § 405.1865).

(3) The decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and whether the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue.

(4) The decision must include appropriate citations to the record evidence and to the applicable law, regulations, CMS Rulings, and general CMS instructions.

(5) A copy of the decision must be mailed promptly to each party to the appeal.

(b)(1) A Board Hearing Decision issued in accordance with paragraph (a) of this section is final and binding on the parties to the Board appeal unless the Hearing Decision is reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(a)(2)(i), (e), and (f), no later than 60 days after the date of receipt by the provider of the Board's decision. A Board Hearing 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.

(2) A Board Hearing Decision that is final under paragraph (b)(1) of this section is subject to the provisions of § 405.1803(d), unless a decision is the subject of judicial review (see § 405.1877).

(3) A final Board decision under paragraph (a) and (b)(1) of this section may be reopened by the Board in accordance with §§ 405.1885 through 405.1889.

§ 405.1873 [Removed].

30. Section 405.1873 is removed.

31. Section 405.1875 is revised to read as follows:

§ 405.1875 Administrator review.

(a) *Basic rule; time limit for rendering Administrator decisions; Board decisions and action subject to immediate review.* The Administrator, at his or her discretion, may immediately review any decision of the Board specified in paragraph (a)(2) of this section. Non-final decisions or actions by the Board are not immediately reviewable, except as provided in paragraph (a)(3) of this section. The Administrator may exercise this discretionary review authority on his or her own motion, or in response to a request from: A party to the Board appeal; CMS; or, in the case of a matter specified in paragraph (a)(3)(i) or (a)(3)(ii) of this section, another affected non-party to a Board appeal. All requests for Administrator review and any other submissions to the Administrator under paragraph (c) of this section must be sent to the Office of the Attorney Advisor. The Office of the Attorney Advisor must examine each Board decision specified in paragraph (a)(2) of this section, and each matter described in §§ 405.1845(g)(3), 405.1853(e)(2), or 405.1857(d)(2), of which it becomes aware, together with any review requests or any other submission made in accordance with the provisions of this section, in order to assist the Administrator's exercise of this discretionary review authority. The Board is required to send to the Office of the Attorney Advisor a copy of each decision specified in paragraphs (a)(2)(i) and (a)(2)(iii) of this section upon issuance of the decision.

(1) The date of rendering any decision after the review by the Administrator must be no later than 60 days after the date of receipt by the provider of a reviewable Board decision or action. For purposes of this section, the date of rendering is the date the Administrator signs the decision, and not the date the decision is mailed or otherwise transmitted to the parties.

(2) The Administrator may immediately review:

(i) A Board Hearing Decision (see § 405.1871).

(ii) A Board Dismissal Decision (see § 405.1836(e)(1) and (e)(2), § 405.1840(c)(2) and (c)(3), § 405.1868(d)(1) and (d)(2)).

(iii) A Board Expedited Judicial Review Decision, but only the question of whether there is Board jurisdiction over a specific matter at issue in the decision; the Administrator may not review the Board's determination in a decision of its authority to decide a legal question relevant to the matter at issue (*see* § 405.1842(h)).

(iv) Any other Board decision or action deemed to be final by the Administrator.

(3) Any decision or action by the Board not specified in paragraph (a)(2)(i) through (a)(2)(iii) of this section, or not deemed to be final by the Administrator under paragraph (a)(2)(iv) of this section, is non-final and not subject to Administrator review until the Board issues one of the decisions specified in paragraph (a)(2) of this section, except the Administrator may review immediately the following matters:

(i) A Board ruling authorizing discovery or disclosure of a matter for which an objection was made based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden (*see* § 405.1853(e)(2)).

(ii) A Board subpoena compelling disclosure of a matter for which an objection was made based on privilege or other protection from disclosure such as case preparation, confidentiality, or undue burden (*see* § 405.1857(d)(2)).

(b) *Illustrative list of criteria for deciding whether to review.* In deciding whether to review a Board decision or other matter specified in paragraphs (a)(2) and (a)(3) of this section, either on his or her own motion or in response to a request for review, the Administrator considers criteria such as whether it appears that:

(1) The Board made an erroneous interpretation of law, regulation, CMS Ruling, or general CMS instructions.

(2) Any Board hearing decision meets the requirements of § 405.1871(a).

(3) The Board erred in refusing to admit certain evidence or in not considering other submitted matter (*see* § 405.1855 and § 405.1865(b)), or in admitting certain evidence or considering other submitted matter.

(4) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to the issuance of a CMS Ruling or other directive needed to clarify a statutory or regulatory provision.

(5) The Board has incorrectly found, assumed, or denied jurisdiction over a specific matter at issue or extended its authority in a manner not provided for by statute, regulation, CMS Ruling, or general CMS instructions.

(6) The decision or other action of the Board requires clarification, amplification, or an alternative legal basis.

(7) A remand to the Board may be necessary or appropriate under the criteria prescribed in paragraph (f) of this section.

(c) *Procedures*—(1) *Review requests.* A party to the Board appeal or CMS may request Administrator review of a Board decision specified in paragraph (a)(2) of this section or a matter described in paragraph (a)(3) of this section. A non-party other than CMS may request Administrator review solely of a matter described in paragraph (a)(3)(i) or (a)(3)(ii) of this section. The date of receipt by the Office of Attorney Advisor of any review request must be no later than 15 days after the date the party or non-party making the request received the Board's decision or other reviewable action.

(2) *Exception.* If a party, or nonparty, as applicable, seeks immediate review of a matter described in § 405.1875(a)(3)(i) or (a)(3)(ii), the request for review must be made as soon as practicable, but in no event later than 5 business days after the day the party or non-party seeking review received notice of the ruling or subpoena.

(i) The request must state the reason(s) why the ruling was in error and the potential harm that may be caused if immediate review is not granted.

(ii) A party or CMS may respond to a request for Administrator review.

(iii) A request for review (or a response to a request) must be submitted in writing, identify the

specific issues for which review is requested, and explain why review is or is not appropriate, under the criteria specified in paragraph (b) of this section or for some other reason.

(iv) A copy of any review request (or response to a request) must be mailed promptly to each party to the appeal, the Office of the Attorney Advisor, and, as applicable, CMS, and any other affected non-party.

(3) *Notice of review*. When the Administrator decides to review a Board decision or other matter specified in paragraphs (a)(2) or (a)(3) of this section, respectively, whether on his or her own motion or upon request, the Administrator must send a written notice to the parties, CMS, and any other affected non-party stating that the Board's decision is reviewed, and indicating the specific issues that is considered. The Administrator may decline to review a Board decision or other matter, or any issue in a decision or matter, even if a request for review is submitted in accordance with paragraph (c)(1) of this section.

(4) *Written submissions on review*. If the Administrator accepts review of the Board's decision or other reviewable action, a party, CMS, or, another affected non-party that properly requested review, may render written submissions regarding the review. The date of receipt by the Office of the Attorney Advisor of any material must be no later than 15 days after the date the party, CMS or other affected non-party submitting comments received the Administrator's notice under paragraph (c)(3) of this section, taking review of the Board decision or other reviewable matter. Any submission must be limited to the issues accepted for Administrator review (as identified in the notice) and be confined to the record of Board proceedings (*see* § 405.1865). The submission may include:

(i) Argument and analysis supporting or taking exception to the Board's decision or other reviewable action;

(ii) Supporting reasons, including legal citations and excerpts of record evidence, for any argument and analysis submitted under paragraph (c)(3)(i) of this section;

(iii) Proposed findings of fact and conclusions of law;

(iv) Rebuttal to any written submission filed previously with the Administrator in accordance with paragraph (c)(3) of this section; or

(v) A request, with supporting reasons, that the decision of other reviewable action be remanded to the Board.

(d) *Ex parte communications prohibited*. All communications from any party, CMS, or other affected non-party, concerning a Board decision (or other reviewable action) that is being reviewed or may be reviewed by the Administrator, must be in writing and must contain a certification that copies were served on all other parties, CMS, and any other affected non-party, as applicable. The communications include, but are not limited to, requests for review and responses to requests for review submitted under paragraph (c)(1) of this section, and written submissions regarding review submitted under paragraph (c)(3) of this section. The Administrator does not consider any communication that does not meet these requirements or is not submitted within the required time limits.

(e) *Administrator's decision*. (1) Upon completion of any review, the Administrator provides a written decision that:

(i) For purposes of review of a Board decision specified in paragraph (a)(2) of this section, affirms, reverses, or modifies the Board's decision, or vacates that decision and remands the case to the Board for further proceedings in accordance with paragraph (f)(1)(i) of this section; or

(ii) For purposes of review of a matter described in paragraph (a)(3) of this section, affirms, reverses, modifies, or remands the Board's remand order, discovery ruling, or subpoena, as applicable, and remands the case to the Board for further proceedings in accordance with paragraph (f)(1)(ii) of this section.

(2) The date of rendering any decision by the Administrator must be no later than 60 days after the date of receipt by the provider of the Board's decision or other reviewable action. The Administrator must promptly mail a copy of his or her decision to the Board, to each party to the appeal, to CMS, and, if applicable, to any other affected non-party.

(3) Any decision by the Administrator must be based on:

(i) Applicable provisions of the law, regulations, CMS Rulings, and general CMS instructions.

(ii) Prior decisions of the Board, the Administrator, and the courts, and any other law that the Administrator finds applicable, whether or not cited in materials submitted to the Administrator.

(iii) The administrative record for the case (see § 405.1865).

(iv) Generally known facts that are not subject to reasonable dispute.

(4) A timely decision by the Administrator that affirms, reverses, or modifies one of the Board decisions specified in paragraph (a)(2) of this section is final and binding on each party to the Board appeal (see § 405.1877(a)(4)). If the final Administrator decision follows review of a Board Hearing Decision, the Administrator's decision is subject to the provisions of § 405.1803(d) unless that final decision is the subject of judicial review (see § 405.1877). The Administrator in accordance with § 405.1885 through § 405.1889 may reopen a final Administrator decision. A decision by the Administrator remanding a matter to the Board for further proceedings in accordance with paragraph (f) of this section is not a final decision for purposes of judicial review (see § 405.1877(a)(4)) or the provisions of § 405.1803(d).

(f) *Remand*. (1) A remand to the Board by the Administrator has the effect for purposes of review:

(i) A Board decision specified in paragraph (a)(2) of this section, vacating the Board's decision and requiring further proceedings in accordance with the Administrator's decision and this subpart; or

(ii) A matter described in paragraph (a)(3) of this section, affirming, reversing, modifying, or remanding the Board's remand order, discovery ruling, or subpoena, as applicable, and returning the case to the Board for further proceedings in accordance with the Administrator's decision and this subpart.

(2) The Administrator may direct the Board to take further action for the development of additional facts or new issues, or to consider the applicability of laws or regulations other than those considered by the Board. The following are not acceptable bases for remand:

(i) Presentation of evidence existing at the time of the Board hearing that was known or reasonably may be known.

(ii) Introduction of a favorable court ruling, regardless of whether the ruling was made or was available at the time of the Board hearing or at the time the Board issued its decision.

(iii) Change in a party's representation, regardless when made.

(iv) Presentation of an alternative legal basis concerning an issue in dispute.

(v) Attempted retraction of a waiver of a right, regardless when made.

(3) After remand, the Board must take the actions required in the Administrator's remand order and issue a new decision in accordance with paragraph (f)(1)(i) of this section, or issue under paragraph (f)(1)(ii) of this section an initial decision or a further remand order, discovery ruling, or subpoena ruling, as applicable.

(4) Administrator review of any decision or other action by the Board after remand is, to the extent applicable, subject to the provisions of paragraphs (a)(2) or (a)(3) of this section.

(5) Besides ordering a remand to the Board, the Administrator may order a remand to any component of HHS or CMS or to an intermediary under appropriate circumstances, including, but not limited to, for the purpose of effectuating a court order (see § 405.1877(g)(2)).

32. Section 405.1877 is revised to read as follows:

§ 405.1877 Judicial review.

(a) *Basis and scope.* (1) Notwithstanding the provisions of 5 U.S.C. 704 or any other provision of law, sections 205(h) and 1872 of the Act provide that a decision or other action by a reviewing entity is subject to judicial review solely to the extent authorized by section 1878(f)(1) of the Act. This section, along with the expedited judicial review provisions of § 405.1842, implements section 1878(f)(1) of the Act.

(2) Section 1878(f)(1) of the Act provides that a provider has a right to obtain judicial review of a final decision of the Board, or of a timely reversal, affirmation, or modification by the Administrator of a final Board decision, by filing a civil action in accordance with the Federal Rules of Civil Procedure in a Federal district court with venue no later than 60 days after the date of receipt by the provider of a final Board decision or a reversal, affirmation, or modification by the Administrator. The Secretary of Health and Human Services (and not the Administrator or CMS itself, or the intermediary) is the only proper defendant in a civil action brought under section 1878(f)(1).

(3) A Board decision is final and subject to judicial review under section 1878(f)(1) of the Act only if the decision—

(i) Is one of the Board decisions specified in § 405.1875(a)(2)(i) through (a)(2)(iii) or, in a particular case, is deemed to be final by the Administrator under § 405.1875(a)(2)(iv); and

(ii) Is not reversed, affirmed, modified, or remanded by the Administrator under § 405.1875(e) and (f) within 60 days of the date of receipt by the provider of the Board's decision. A provider is not required to seek Administrator review under § 405.1875 first in order to seek judicial review of a Board decision that is final and subject to judicial review under section 1878(f)(1) of the Act.

(4) If the Administrator timely reverses, affirms, or modifies one of the Board decisions specified in § 405.1875(a)(2)(i) through (a)(2)(iii) or deemed to be final by the Administrator in a particular case under § 405.1875(a)(2)(iv), the Administrator's reversal, affirmation, or modification is the only decision subject to judicial review under section 1878(f)(1) of the Act. A remand of a Board decision by the Administrator to the Board vacates the decision; neither the Board's decision nor the Administrator's remand is a final decision subject to judicial review under section 1878(f)(1) of the Act (see § 405.1875(e)(4), (f)(1), and (f)(4)).

(b) *Determining when a civil action may be filed—*

(1) *General rule.* Under section 1878(f)(1) of the Act, the 60-day periods for Administrator review of a decision by the Board, and for judicial review of any final Board decision, respectively, both begin to run on the same day. Paragraphs (b)(2), (b)(3) and (b)(4) of this section identify how various actions or inaction by the Administrator within the 60-day review period determine the scope and timing of any right a provider may have to judicial review under section 1878(f)(1) of the Act.

(2) *Administrator declines review.* If the Administrator declines any review of a Board decision specified in § 405.1875(a)(2), whether through inaction or in a written notice issued under § 405.1875(c)(2), the provider must file any civil action seeking judicial review of the Board's final decision under section 1878(f)(1) of the Act no later than 60 days after the date of receipt by the provider of the Board's decision.

(3) *Administrator accepts review and renders timely decision.* Where the Administrator decides to review, in a notice under § 405.1875(c)(2), any issue in a Board decision specified as final, or deemed as final by the Administrator, under § 405.1875(a)(2) and he or she subsequently makes a decision within the 60-day review period (see § 405.1875(a)(1)), the provider has no right to obtain judicial review under section 1878(f)(1) of the Act of the Board's decision. If the Administrator timely reverses, affirms, or modifies the Board's decision, the provider's only right under section 1878(f)(1) of the Act is to request judicial review of the Administrator's decision by filing a civil action no later than 60 days after the date of receipt by the provider of the Administrator's decision (see § 405.1877(a)(3)). If the Administrator timely vacates the Board's decision and remands for further proceedings (see § 405.1875(f)(1)(i)), a provider has no right to judicial review under section 1878(f)(1) of the Act of the Board's decision or of the Administrator's remand (see § 405.1877(a)(3)).

(4) *Administrator accepts review and timely decision is not rendered.* If the Administrator decides to review, in a notice under § 405.1875(c)(2), any issue in a Board decision specified as final, or deemed to be final by the Administrator, under § 405.1875(a)(2), but he or she does not render a decision within the 60-day review period, this subsequent inaction constitutes an affirmation of the Board's decision by the Administrator. In this case, the provider must file any civil action requesting judicial review of the Administrator's final decision under section 1878(f)(1) of the Act no later than 60 days after the expiration of the 60-day period for a decision by the Administrator under § 405.1875(a)(1) and § 405.1875(e)(2).

(c) *Statutory limitations on and preclusion of judicial review.* The Act limits or precludes judicial review of certain matters at issue. Limitations on and preclusions of judicial review include the following:

(1) A finding in an intermediary determination that expenses incurred for items and services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act, and § 411.15 of this chapter, is not reviewable by the Board (see § 405.1840(b)(1)) and is not subject to judicial review under section 1878(f)(1) of the Act; the finding is subject to judicial review solely in accordance with the applicable provisions of sections 1155, 1869, and 1879(d) of the Act, and of subparts G and H of part 405 and subpart B of part 473, as applicable.

(2) Certain matters affecting payments to hospitals under the prospective payment system are completely removed from administrative and judicial review, as provided in section 1886(d)(7) of the Act, and § 405.1804 and § 405.1840(b)(2).

(3) Any Board remand order, or discovery ruling or subpoena specified in § 405.1875(a)(3)(i) through (a)(3)(ii), or a decision by the Administrator following immediate review of a Board remand order, discovery ruling, or subpoena, is not subject to immediate judicial review under section 1878(f)(1) of the Act. Judicial review of all non-final Board actions, including any such Board remand order, discovery ruling, and, except as provided in § 405.1857(e), subpoena, is limited to

review of a final agency decision as described in § 405.1877(a).

(d) *Group appeals.* If a final decision is issued by the Board or rendered by the Administrator, as applicable, in any group appeal brought under § 405.1837, those providers in the group appeal that seek judicial review of the final decision under section 1878(f)(1) of the Act must file a civil action as a group (see § 405.1877(e)(2)) for the specific matter at issue and common factual or legal question that was addressed in the final agency decision in the group appeal.

(e) *Venue for civil actions.* (1) *Single provider appeals.* A civil action under section 1878(f)(1) of the Act requesting judicial review of a final decision of the Board or the Administrator, as applicable, in a single provider appeal under § 405.1835 must be brought in the District Court of the United States for the judicial district in which the provider is located or in the United States District Court for the District of Columbia.

(2) *Group appeals.* A civil action under section 1878(f)(1) of the Act seeking judicial review of a final decision of the Board or the Administrator, as applicable, in a group appeal under § 405.1837 must be brought in the District Court of the United States for the judicial district in which the greatest number of providers participating in both the group appeal and the civil action are located or in the United States District Court for the District of Columbia.

(f) *Service of process.* Process must be served as described under 45 CFR part 4.

(g) *Remand by a court*—(1) *General rule.* Under section 1874 of the Act, and § 421.5(b) of this chapter, the Secretary is the real party in interest in a civil action seeking relief under title XVIII of the Act. The Secretary has delegated to the Administrator the authority under section 1878(f)(1) of the Act to review decisions of the Board and, as applicable, render a final agency decision. If a court, in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter pertaining to Medicare payment to the provider, orders a remand for further action by the Secretary, any component of HHS or CMS, or the intermediary, a remand order must be deemed, except as provided in paragraph (g)(3) of this section, to be directed to the Administrator in the first instance, regardless of whether the court's remand order refers to the Secretary, the Administrator, the Board, any other component of HHS or CMS, or the intermediary.

(2) *Exception.* The provisions of paragraphs (g)(2) and (g)(3) of this section do not apply to the extent they may be inconsistent with the court's remand order or any other order of the court regarding the civil action.

(3) *Procedures.* (i) Upon receiving notification of a court remand order, the Administrator must prepare an appropriate remand order and, if applicable, file the order in any Board appeal at issue in the civil action.

(ii) The Administrator's remand order must describe the specific requirements of the court's remand order; require compliance with those requirements by the pertinent component of HHS or CMS or by the intermediary, as applicable; and remand the matter to the appropriate entity for further action.

(iii) After the entity named in the Administrator's remand order completes its response to that order, the entity's response after remand is subject to further proceedings before the Board or the Administrator, as applicable, in accordance with this subpart. For example, if the intermediary issues a revised intermediary determination after remand, the provider may request a Board hearing on the revised determination (see § 405.1803(d) and § 405.1889); or, if the intermediary hearing officer(s) or the Board issues a new decision after remand, a decision may be reviewed by a CMS reviewing official or the Administrator, respectively (see § 405.1834, § 405.1875(f)(4)).

(h) *Implementation of final court judgment.* (1) Where a final, non-appealable court judgment is issued in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter affecting Medicare payment, a court judgment is subject to the provisions of § 405.1803(d).

(2) The provisions of paragraph (h)(1) of this section do not apply to the extent they may be inconsistent with the court's final judgment or any other order of a court regarding the civil action.

33. Section 405.1885 is revised to read as follows:

§ 405.1885 Reopening an intermediary determination or reviewing entity decision.

(a) *Overview.* (1) A Secretary determination, a intermediary determination, or a decision by a reviewing entity (see § 405.1801(a)) may be reopened, for findings on matters at issue in a determination or decision, by the intermediary or by the applicable reviewing entity, respectively.

(2) A determination or decision may be reopened either through own motion of CMS (for Secretary determinations), the intermediary or reviewing entity, by notifying the parties to the determination or decision (as specified in § 405.1887), or by granting the request of the provider affected by the determination or decision.

(3) An intermediary's discretion to reopen or not reopen a matter is subject to a contrary directive from CMS to reopen or not reopen that matter.

(4) If CMS directs an intermediary to reopen a matter, reopening is considered an own motion reopening by the intermediary. A reopening may result in a revision of any matter at issue in the determination or decision.

(5) If a matter is reopened and a revised determination or decision provided, a revised determination or decision is appealable to the extent provided in § 405.1889.

(6) A determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of this subpart and is not subject to further administrative review or judicial review.

(b) *Time limits.* (1) An own motion reopening is timely only if the notice of intent to reopen is mailed no later than 3 years after the date of the determination or decision that is the subject of the reopening. The date the notice is mailed is presumed to be the date indicated on the notice unless it is shown by a preponderance of the evidence that the notice was mailed on a later date.

(2) A reopening made upon request is timely only if the request to reopen is received by CMS, the intermediary, or reviewing entity, as appropriate, no later than 3 years after the date of the determination or decision that is the subject of the requested reopening. The date of receipt by CMS, the intermediary, or the reviewing entity of the request to reopen is presumed to be the date stamped ''Received'' unless it is shown by a preponderance of the evidence that CMS, the intermediary, or the reviewing entity received the request on an earlier date. A request to reopen does not toll the time in which to appeal an otherwise appealable determination or decision.

(3) No Secretary or intermediary determination, or decision by a reviewing entity, may be reopened after the 3-year period specified in paragraphs (b)(1) and (b)(2) of this section, except as follows: A Secretary or intermediary determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or

similar fault of any party to the determination or decision.

(c) *Jurisdiction for reopening.* Jurisdiction for reopening an intermediary determination or intermediary hearing decision rests exclusively with the intermediary or intermediary hearing officer(s) that rendered the determination or decision (or, where applicable, with the successor intermediary), subject to a directive from CMS to reopen or not reopen the determination or decision. Jurisdiction for reopening a Secretary determination, CMS reviewing official decision, a Board decision, or an Administrator decision rests exclusively with CMS, the CMS reviewing official, Board or Administrator, respectively.

(1) *CMS-directed reopenings.* CMS may direct an intermediary or intermediary hearing officer(s) to reopen and revise any matter, subject to the time limits specified in paragraph (b) of this section, and subject to the limitation expressed in paragraph (c)(2) of this section, by providing explicit direction to the intermediary or intermediary hearing officer(s) to reopen and revise.

(i) *Examples.* An intermediary determination or intermediary hearing decision must be reopened and revised if CMS provides explicit notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary. CMS may direct the intermediary to reopen a particular intermediary determination or decision in order to implement a final agency decision (see § 405.1833, § 405.1871(b), § 405.1875, § 405.1877(a)), a final, non-appealable court judgment, or an agreement to settle an administrative appeal or a lawsuit, regarding the same determination or decision.

(ii) [Reserved]

(2) *Prohibited reopenings.* A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening a CMS or intermediary determination, an intermediary hearing decision, a CMS reviewing official decision, a Board decision, or an Administrator decision, under this section.

(3) *Reopening by CMS or intermediary of determination currently on appeal to the Board.* CMS or an intermediary may reopen, on its own motion or on request of the provider(s), a Secretary or intermediary determination that is currently pending on appeal before the Board. The scope of the reopening may include any matter covered by the determination, including those specific matters that are appealed to the Board or the Administrator. The intermediary must send a copy of the notice required under § 405.1887(a) to the Board specifically informing that matter(s) to be addressed by the reopening are currently under appeal to the Board or are covered by the same determination that is under appeal.

(4) *Reopening by intermediary of determination within the time for appealing that determination to the Board.* CMS or an intermediary may reopen, on its own motion or on request of the provider(s), Secretary or intermediary determination for which no appeal was taken to the Board, but for which the time to appeal to the Board has not yet expired, by sending the notice specified in § 405.1887(a).

34. Section 405.1887 is revised to read as follows:

§ 405.1887 Notice of reopening; effect of reopening.

(a) In exercising its reopening authority under § 405.1885, CMS (for Secretary determinations), the intermediary or the reviewing entity, as applicable, must provide written notice to all parties to the determination or decision that is the subject of the reopening. Notices of reopening by a CMS reviewing official or the Board also must be sent promptly to the Administrator. For additional notice requirements for intermediary reopenings of determinations that are currently pending before the Board or the Administrator see §§ 405.1885(c)(3) and (c)(4).

(b) Upon receipt of the notice required under § 405.1887(a), the parties to the prior Secretary or intermediary determination or decision by a reviewing entity, as applicable, must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their positions.

(c) Upon concluding its reopening, CMS, the intermediary or the reviewing entity, as applicable, must provide written notice promptly to all parties to the determination or decision that is the subject of the reopening, informing the parties as to what matter(s), if any, is revised, with a complete explanation of the basis for any revision.

(d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening but is not revised is not within the proper scope of an appeal of a revised determination or decision (see § 405.1889).

35. Section 405.1889 is revised to read as follows:

§ 405.1889 Effect of a revision; issue-specific nature of appeals of revised determinations and decisions.

(a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 are applicable.

(b) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision; any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

36. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

36a. The heading for part 413 is revised to read as set forth above.

§ 413.30 [Amended]

37. The last sentence in paragraph (c)(1) of § 413.30 is revised to read as follows:

* * * * *

(c) * * *

(1) * * * The time required for CMS to review the request is considered good cause for the granting of an extension of the time limit for requesting an intermediary hearing or a Provider Reimbursement Review Board (Board) hearing as specified in § 405.1813 and § 405.1836 of this chapter, respectively.

* * * * *

§ 413.40 [Amended]

38. Paragraph (e)(5) of § 413.40 is revised to read as follows:

* * * * *

(e) * * *

(5) *Extending the time limit for review of NPR.* The time required to review the

request is considered good cause for the granting of an extension of the time limit for requesting an intermediary hearing or a Board hearing as specified in § 405.1813 and § 405.1836 of this chapter, respectively.

* * * * *

§ 413.64 [Amended]

39. The last sentence in paragraph (j)(1) of § 413.64 is revised to read as follows:

* * * * *

(j) * * *

(1) * * * The interest begins to accrue on the first day of the first month following the 180-day period described in § 405.1835(a)(3)(i) or (a)(3)(ii) of this chapter, as applicable.

* * * * *

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

40. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

§ 417.576 [Amended]

41. Section 417.576 is amended as follows:

a. In paragraph (d)(4), remove the phrase ''a hearing in accordance with subpart R of part 405 of this chapter.'' and add, in its place, ''a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.''

b. In paragraph (e)(2), remove the phrase ''a hearing under subpart R of part 405 of this chapter.'' and add, in its place ''a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.''

§ 417.810 [Amended]

42. Section 417.810 is amended as follows:

a. In paragraph (c)(2), remove the phrase ''a hearing as provided in part 405, subpart R of this chapter.'' and add, in its place, ''a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.''

b. In paragraph (d)(3), remove the phrase ''a hearing on the determination under the provisions of part 405, subpart R of this chapter.'' and add, in its place, ''a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.''

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: June 5, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 4, 2004.

Tommy G. Thompson,

Secretary.

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