

(3) The amount in controversy (as determined in § 405.1839(a)) is \$10,000 or more.

(b) *Prospective payment exceptions.* Except with respect to matters for which administrative or judicial review is not permitted as specified in § 405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to hearing based on late intermediary determination about reasonable cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination—see § 405.1803(a)) provided such delay was not occasioned by the fault of the provider.

[48 FR 39835, Sept. 1, 1983]

§ 405.1837 Group appeal.

(a) *Criteria for group appeals.* Subject to paragraph (b) of this section, a group of providers may bring an appeal before the Board but only if—

(1) Each provider in the group is identified as one which would, upon the filing of a request for a hearing before the Board, but without regard to the \$10,000 amount in controversy requirement, be entitled to a hearing under § 405.1835;

(2) The matters at issue involve a common question of fact or of interpretation of law, regulations or CMS Rulings; and

(3) The amount in controversy is, in the aggregate, \$50,000 or more.

(b) *Providers under common ownership or control.* Effective April 20, 1983, any appeal filed by providers that are under common ownership or control must be brought by the providers as a group appeal in accordance with the provisions of paragraph (a) of this section with respect to any matters involving an issue common to the providers and for which the amount in controversy is, in the

aggregate, \$50,000 or more (see § 405.1841(a)(2)). A single provider involved in a group appeal that also wishes to appeal issues that are not common to the other providers in the group must file a separate hearing request (see § 405.1841(a)(1)) and must separately meet the requirements in § 405.1811 or § 405.1835, as applicable.

[48 FR 39836, Sept. 1, 1983]

§ 405.1839 Amount in controversy.

(a) *Single appeals.* The \$1,000 amount in controversy required under § 405.1809 for an intermediary hearing and the \$10,000 amount in controversy required under § 405.1835 for a Board hearing is, as applicable to the matters for which the provider has requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the provider on other than a reasonable cost basis under the prospective payment system from the total amount that would be payable after a recomputation that takes into account any exclusion, exception, adjustment, or additional payment denied the provider under part 412 of this chapter, as applicable;

(ii) The total of the payment due the provider on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed by the provider; and

(iii) The adjusted total reimbursable costs due the provider on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed by the provider.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

(b) *Group appeals.* The \$50,000 amount in controversy required under § 405.1837 for group appeals to the Board is, as applicable to the common matters for

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which the group of providers have requested a hearing, the combined total of the amounts computed as follows:

(1) *Providers under prospective payment.* For providers that are paid under the prospective payment system, by deducting—

(i) The total of the payment due the providers (in the aggregate) on other than a reasonable cost basis under the prospective payment system from the total amount that would be payable to the providers (in the aggregate) after a recomputation that takes into account any applicable exception, exclusion, adjustment, or additional payment denied the providers under part 412 of this chapter.

(ii) The total of the payment due the providers (in the aggregate) on a reasonable cost basis under the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers; and

(iii) The adjusted total reimbursable costs due the providers (in the aggregate) on a reasonable cost basis under other than the prospective payment system from the total reimbursable costs claimed in the aggregate by the providers.

(2) *Providers not under prospective payment.* For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the providers (in the aggregate) on a reasonable cost basis from the total reimbursable costs claimed in the aggregate by the providers.

[49 FR 323, Jan. 3, 1984]

§ 405.1841 Time, place, form, and content of request for Board hearing.

(a) *General requirements.* (1) The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified in § 405.1835(c). Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be

accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

(2) Effective April 20, 1983, any request for a Board hearing by providers that are under common ownership or control (see § 413.17 of this chapter) must be brought by the providers as a group appeal (see § 405.1837(b)) with respect to any matters at issue involving a question of fact or of interpretation of law, regulations, or CMS Rulings common to the providers and for which the amount in controversy is \$50,000 or more in the aggregate. If a group appeal is filed, the provider seeking the appeal must be separately identified in the request for hearing, which must be prepared and filed consistently with the requirements of paragraph (a)(1) of this section.

(b) *Extension of time limit for good cause.* A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary's determination is mailed to the provider.

[48 FR 39836, Sept. 1, 1983, as amended at 51 FR 34793, Sept. 30, 1986]

§ 405.1842 Expediting Board proceedings.

(a) *Basis and purpose.* This section implements section 1878(f)(1) of the Social Security Act, as amended by section 955 of Public Law 96-499 (42 U.S.C. 1395oo(f)(1)). The amendment provides an opportunity for providers to obtain expedited administrative review when the Board determines that it does not have the authority to decide a question of law, regulation, or CMS Ruling relevant to the case (see § 405.1867).

(b) *Basic rule.* (1) Except as provided in paragraph (b)(4) of this section, a provider may submit a written request