

§ 466.104

§ 466.104 Coordination of activities.

In order to achieve efficient and economical review, a PRO must coordinate its activities (including information exchanges) with the activities of—

- (a) Medicare fiscal intermediaries and carriers;
- (b) Other PROs; and
- (c) Other public or private review organizations as may be appropriate.

PART 473—RECONSIDERATIONS AND APPEALS

Subpart A [Reserved]

Subpart B—Utilization and Quality Control Peer Review Organization (PRO) Reconsiderations and Appeals

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AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A [Reserved]

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Subpart B—Utilization and Quality Control Peer Review Organization (PRO) Reconsiderations and Appeals

SOURCE: 50 FR 15372, Apr. 17, 1985, unless otherwise noted.

§ 473.10 Scope.

This subpart establishes the requirements and procedures for—

(a) Reconsiderations conducted by a Utilization and Quality Control Peer Review Organization (PRO) or its subcontractor of initial denial determinations concerning services furnished or proposed to be furnished under Medicare;

(b) Hearings and judicial review of reconsidered determinations; and

(c) PRO review of a change in diagnostic and procedural coding information.

[50 FR 15372, Apr. 17, 1985; 50 FR 41887, Oct. 16, 1985]

§ 473.12 Statutory basis.

(a) Under section 1154 of the Act, a PRO may make an initial determination that services furnished or proposed to be furnished are not reasonable, necessary, or delivered in the most appropriate setting.

(b) Under section 1155 of the Act, the following rules apply:

(1) A Medicare beneficiary, a provider, or an attending practitioner who is dissatisfied with an initial denial determination under paragraph (a) of this section is entitled to a reconsideration by the PRO that made that determination.

(2) The beneficiary is also entitled to the following:

(i) A hearing by an administrative law judge if \$200 or more is still in controversy after a reconsidered determination.

(ii) Judicial review if \$2000 or more is still in controversy after a final determination by the Department.

(c) Under section 1866(a)(1)(F) of the Act, a hospital that is reimbursed by the Medicare program must maintain an agreement with a PRO under which

the PRO reviews the validity of diagnostic information furnished by the hospital.

[50 FR 15372, Apr. 17, 1985, as amended at 60 FR 50442, Sept. 29, 1995]

§ 473.14 Applicability.

(a) *Basic provision.* This subpart applies to reconsiderations and hearings of a PRO initial denial determination involving the following issues:

- (1) Reasonableness of services.
- (2) Medical necessity of services.

(3) Appropriateness of the inpatient setting in which services were furnished or are proposed to be furnished.

(b) *Concurrent appeal.* A reconsideration or hearing provided under this subpart fulfills the requirements of any other review, hearing, or appeal under the Act to which a party may be entitled with respect to the same issues.

(c) *Nonapplicability of rules to related determinations.* (1) A PRO may not reconsider its decision whether to grant grace days.

(2) Limitation of liability determinations on excluded coverage of certain services are made under section 1879 of the Act. Initial determinations under section 1879 and further appeals are governed by the reconsideration and appeal procedures in part 405, subpart G of this chapter for determinations under Medicare Part A, and part 405, subpart H of this chapter for determinations under Medicare Part B. References in those subparts to initial and reconsidered determinations made by an intermediary, carrier or HCFA should be read to mean initial and reconsidered determinations made by a PRO.

[50 FR 15372, Apr. 17, 1985; 50 FR 41887, Oct. 16, 1985]

§ 473.15 PRO review of changes resulting from DRG validation.

(a) *General rules.* (1) A provider or practitioner dissatisfied with a change to the diagnostic or procedural coding information made by a PRO as a result of DRG validation under section 1866(a)(1)(F) of the Act is entitled to a review of that change if—

- (i) The change caused an assignment of a different DRG; and
- (ii) Resulted in a lower payment.

(2) A beneficiary may obtain a review of a PRO DRG coding change only if that change results in noncoverage of a furnished service.

(3) The individual who reviews changes in DRG procedural or diagnostic information must be a physician, and the individual who reviews changes in DRG coding must be qualified through training and experience with ICD-9-CM coding.

(b) *Procedures.* Procedures described in §§ 473.18 through 473.36, and 473.48 (a) and (c) for a PRO reconsideration or reopening also apply to PRO review of a DRG coding change.

(c) *Finality of review.* No additional review or appeal for matters governed by paragraph (a) of this section is available.

[50 FR 15372, Apr. 17, 1985; 50 FR 41887, Oct. 16, 1985]

§ 473.16 Right to reconsideration.

A beneficiary, provider or practitioner who is dissatisfied with a PRO initial denial determination on one of the issues specified in § 473.14(a) has a right to a reconsideration of that determination by the PRO that made the initial denial determination.

§ 473.18 Location for submitting requests for reconsideration.

(a) *Beneficiaries.* Except as provided in paragraph (c) of this section concerning requests for expedited reconsideration, a beneficiary who wishes to obtain a reconsideration must submit a written request to one of the following:

- (1) The PRO or the PRO subcontractor that made the initial determination.
- (2) An SSA District Office.
- (3) A Railroad Retirement Board Office, if the beneficiary is a railroad retiree.

(b) *Others.* A provider, physician or other practitioner that wishes to obtain reconsideration must submit a written request to the PRO or PRO subcontractor that made the initial determination.

(c) *Expedited reconsideration.* A request for an expedited reconsideration of a preadmission denial determination must be submitted directly to the PRO.