

§ 473.26 Delegation of the reconsideration function.

A PRO may delegate the authority to reconsider an initial determination to a nonfacility subcontractor, including the organization that made the initial determination as a PRO subcontractor.

§ 473.28 Qualifications of a reconsideration reviewer.

A reconsideration reviewer must be someone who is—

- (a) Qualified under § 466.98 of this chapter to make an initial determination.
- (b) Not the individual who made the initial denial determination.
- (c) A specialist in the type of services under review, except where meeting this requirement would compromise the effectiveness or efficiency of PRO review.

§ 473.30 Evidence to be considered by the reconsideration reviewer.

A reconsidered determination must be based on—

- (a) The information that led to the initial determination;
- (b) New information found in the medical records; or
- (c) Additional evidence submitted by a party.

§ 473.32 Time limits for issuance of the reconsidered determination.

(a) *Beneficiaries.* If a beneficiary files a timely request for reconsideration of an initial denial determination, the PRO must complete its reconsidered determination and send written notice to the beneficiary within the following time limits—

- (1) Within three working days after the PRO receives the request for reconsideration if—
 - (i) The beneficiary is still an inpatient in a hospital for the stay in question when the PRO receives the request for reconsideration; or
 - (ii) The initial determination relates to institutional services for which admission to the institution is sought, the initial determination was made before the patient was admitted to the institution; and a request was submitted timely for an expedited reconsideration.

(2) Within 10 working days after the PRO receives the request for reconsideration if the beneficiary is still an inpatient in a SNF for the stay in question when the PRO receives the request for reconsideration.

(3) Within 30 working days after the PRO receives the request for reconsideration if—

- (i) The initial determination concerns ambulatory or noninstitutional services;
 - (ii) The beneficiary is no longer an inpatient in a hospital or SNF for the stay in question; or
 - (iii) The beneficiary does not submit a request for expedited reconsideration timely.
- (b) *Providers or practitioners.* If the provider or practitioner files a request for reconsideration of an initial determination, the PRO must complete its reconsidered determination and send written notice to the provider or practitioner within 30 working days.

§ 473.34 Notice of a reconsidered determination.

(a) *Notice to parties.* A written notice of a PRO reconsidered determination must contain the following:

- (1) The basis for the reconsidered determination.
- (2) A detailed rationale for the reconsidered determination.
- (3) A statement explaining the Medicare payment consequences of the reconsidered determination.
- (4) A statement informing the parties of their appeal rights, including the information concerning what must be included in the request for hearing, the amount in controversy, locations for submitting a request for an administrative hearing and the time period for filing a request.

(b) *Notice to payers.* (1) A PRO must provide written notice of its reconsidered determination to the appropriate Medicare intermediary or carrier within 30 days if the initial determination is modified or reversed.

(2) This notice must contain adequate information to allow the intermediary or carrier to locate the claim file. This must include the name of the beneficiary, the Health Insurance Claim Number, the name of the provider, date of admission, and dates or