

(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. Redesignated at 64 FR 66279, Nov. 24, 1999]

§ 478.14 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. Redesignated at 64 FR 66279, Nov. 24, 1999]

§ 478.15 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. Redesignated at 64 FR 66279, Nov. 24, 1999]

§ 478.16 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.

§ 478.18 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.