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 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 to the Board, with supporting documentation, to determine whether the Board has the authority to decide a question of law, regulations, or CMS Rulings relevant to and controlling upon an issue to be reviewed by the Board. The Board is required to make an expedited review determination in writing, either denying or granting the request, within 30 days after the date of receipt of the request, as defined in paragraph (1) of this section. The Board may also issue a determination on its own motion that it lacks authority to decide a question of law, regulations or CMS Rulings.

(2) The Board must determine that the provider (including each provider in a group appeal) is entitled to a hearing under section 1878(a) of the Act before making the determination described in paragraph (b)(1) of this section. Thus, the provider must file (or have already filed) a written request for a Board hearing that meets the requirements in § 405.1841. The information and documentation required with respect to the filing of a request for a hearing is used by the Board to determine jurisdiction under section 1878(a) of the Act.

(3) A provider's request for an expedited review determination cannot be considered to be filed with the Board, nor can the 30-day time period during which the Board is required to make an expedited review determination begin, until such time as the Board accepts jurisdiction of the case.

(4) Proceedings conducted by the Board under an authority other than section 1878(a) of the Act and §§ 405.1835 through 405.1873 of this subpart are not hearings for purposes of this section and are not subject to the expedited Board proceedings set forth in this section. For example, proceedings concerning reimbursement for capital expenditures conducted under section 1122(f) of the Act and § 405.1890 of this subpart are not hearings for purposes of this section. (Section 1122(f) specifically bars any administrative or judicial review.)

(c) *''Own motion'' review.* If the Board is considering issuing a determination on its own motion that it lacks the authority to decide a question of law, regulations, or CMS Rulings, it will notify