

510.310 Appeals process.

(a) Notice of calculation error (first level of appeal). Subject to the limitations on review in subpart D of this part, if a participant hospital wishes to dispute calculations involving a matter related to payment, reconciliation amounts, repayment amounts, the use of quality measure results in determining the composite quality score, or the application of the composite quality score during reconciliation, the participant hospital is required to provide written notice of the calculation error, in a form and manner specified by CMS.

(1) Unless the participant hospital provides such notice, CMS deems final the CJR reconciliation report 45 calendar days after it is issued and proceeds with the payment or repayment processes as applicable.

(2) If CMS receives a notice of a calculation error within 45 calendar days of the issuance of the reconciliation report, CMS responds in writing within 30 calendar days to either confirm that there was an error in the calculation or verify that the calculation is correct, although CMS reserves the right to an extension upon written notice to the participant hospital.

(3) Only participant hospitals may use the dispute resolution process described in this part.

(4) Only participant hospitals may use the notice of calculation error process described in this part.

(b) Dispute resolution process (second level of appeal). (1) If the participant hospital is dissatisfied with CMS's response to the notice of a calculation error, the participant hospital may request a reconsideration review in a form and manner as specified by CMS.

(2) The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the participant hospital's assertion that CMS or its representatives did not accurately calculate the NPRA, the reconciliation payment, or the repayment amount in accordance with § 510.305.

(3) If CMS does not receive a request for reconsideration from the participant hospital within 10 calendar days of the issue date of CMS's response to the participant hospital's notice of calculation error, then CMS's response to the calculation error is deemed final and CMS proceeds with reconciliation payment or repayment processes, as applicable, as described in § 510.305.

(4) A CMS reconsideration official notifies the participant hospital in writing within 15 calendar days of receiving the participant hospital's review request of the following:

(i) The date, time, and location of the review.

(ii) The issues in dispute.

(iii) The review procedures.

(iv) The procedures (including format and deadlines) for submission of evidence.

(5) The CMS reconsideration official takes all reasonable efforts to schedule the review to occur no later than 30 days after the date of receipt of the notification.

(6) The provisions at § 425.804(b), (c), and (e) of this chapter are applicable to reviews conducted in accordance with the reconsideration review process for CJR.

(7) The CMS reconsideration official issues a written determination within 30 days of the review. The determination is final and binding.

(c) Exception to the process. If the participant hospital contests a matter that does not involve an issue contained in, or a calculation that contributes to, a CJR reconciliation report, a notice of calculation error is not required. In these instances, if CMS does not receive a request for reconsideration from the participant hospital within 10 calendar days of the notice of the initial determination, the initial determination is deemed final and CMS proceeds with action indicated in the initial determination. This does not apply to the limitations on review in paragraph (e) of this section.

(d) Notice of a participant hospital's termination from the CJR model. If a participant hospital receives notification that it has been terminated from the CJR model, it must provide a written notice to CMS requesting review of the termination within 10 calendar days of the notice. CMS has 30 days to respond to the participant hospital's request for review. If the participant hospital fails to notify CMS, the termination is deemed final.

(e) Limitations on review. In accordance with section 1115A(d)(2) of the Act, there is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:

(1) The selection of models for testing or expansion under section 1115A of the Act.

(2) The selection of organizations, sites, or participants to test those models selected.

(3) The elements, parameters, scope, and duration of such models for testing or dissemination.

(4) Determinations regarding budget neutrality under section 1115A(b)(3) of Act.

(5) The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B) of Act.

(6) Decisions about expansion of the duration and scope of a model under section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in section 1115A(c)(1) or (2) of the Act.