

§ 498.20

42 CFR Ch. IV (10-1-04 Edition)

and one copy to the ALJ or the Departmental Appeals Board, as appropriate. The material may be filed by mail or in person and must include a statement certifying that a copy has been furnished to the other party.

(b) *Opportunity for rebuttal.* (1) The other party will have 20 days from the date of mailing or personal service to submit any rebuttal statement or additional evidence. If a party submits a rebuttal statement or additional evidence, it must file an original and one copy with the ALJ or the Board and furnish a copy to the other party.

(2) The ALJ or the Board will grant an opportunity to reply to the rebuttal statement only if the party shows good cause.

**Subpart B—Initial, Reconsidered, and Revised Determinations**

**§ 498.20 Notice and effect of initial determinations.**

(a) *Notice of initial determination*—(1) *General rule.* CMS or the OIG, as appropriate, mails notice of an initial determination to the affected party, setting forth the basis or reasons for the determination, the effect of the determination, and the party’s right to reconsideration, if applicable, or to a hearing.

(2) *Special rules: Independent laboratories and suppliers of portable x-ray services.* If CMS determines that an independent laboratory or a supplier of portable x-ray services no longer meets the conditions for coverage of some or all of its services, the notice—

(i) Specifies an effective date of termination of coverage that is at least 15 days after the date of the notice;

(ii) Is also sent to physicians, hospitals, and other parties that might use the services of the laboratory or supplier; and

(iii) In the case of laboratories, specifies the categories of laboratory tests that are no longer covered.

(3) *Special rules: Nonparticipating hospitals that elect to claim payment for emergency services.* If CMS determines that a nonparticipating hospital no longer qualifies to elect to claim payment for all emergency services furnished in a calendar year, the notice—

(i) States the calendar year to which the determination applies;

(ii) Specifies an effective date that is at least 5 days after the date of the notice; and

(iii) Specifies that the determination applies to services furnished, in the specified calendar year, to patients accepted (as inpatients or outpatients) on or after the effective date of the determination.

(4) *Other special rules.* Additional rules pertaining, for example, to content and timing of notice, notice to the public and to other entities, and time allowed for submittal of additional information, are set forth elsewhere in this chapter, as follows:

Part 405 Subpart X—for rural health clinics.  
Part 416—for ambulatory surgical centers.  
Part 489—for providers, when their provider agreements have been terminated.

Part 1001, Subpart B—for excluded or suspended providers, suppliers, physicians, or practitioners.

Part 1001, Subpart C—for providers, when their provider agreements are terminated by the OIG.

Part 1004—for sanctioned providers and practitioners.

(b) *Effect of initial determination.* An initial determination is binding unless it is—

(1) Reconsidered in accordance with § 498.24;

(2) Reversed or modified by a hearing decision in accordance with § 498.78; or

(3) Revised in accordance with § 498.32 or § 498.100.

**§ 498.22 Reconsideration.**

(a) *Right to reconsideration.* CMS reconsiders any initial determination that affects a prospective provider or supplier, or a hospital seeking to qualify to claim payment for all emergency hospital services furnished in a calendar year, if the affected party files a written request in accordance with paragraphs (b) and (c) of this section. (None of the determinations made by the OIG are subject to reconsideration.)

(b) *Request for reconsideration: Manner and timing.* The affected party specified in paragraph (a) of this section, if dissatisfied with the initial determination may request reconsideration by filing the request—

(1) With CMS or with the State survey agency;