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in paragraphs (b) through (d) of this section.

(b) *Global or complete service billing representing both the professional and technical components of the procedure.* If a fee is billed for a global service, the amount of payment subject to the deductible is equal to 80 percent of the least of the following:

(1) The actual charge for the service.

(2) The amount established for the global procedure for a diagnostic bilateral mammogram under the fee schedule for physicians' services set forth at part 414, subpart A.

(3) The payment limit for the procedure. For screening mammography services furnished in CY 1994, the payment limit is \$59.63. On January 1 of each subsequent year, the payment limit is updated by the percentage increase in the Medicare Economic Index (MEI) and reflects the relationship between the relative value units for the professional and technical components of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(c) *Professional component billing representing only the physician's interpretation for the procedure.* If the professional component of screening mammography services is billed separately, the amount of payment for that professional component, subject to the deductible, is equal to 80 percent of the least of the following:

(1) The actual charge for the professional component of the service.

(2) The amount established for the professional component of a diagnostic bilateral mammogram under the fee schedule for physicians' services.

(3) The professional component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

(d) *Technical component billing representing other resources involved in furnishing the procedure.* If the technical component of screening mammography services is billed separately, the amount of payment, subject to the deductible, is equal to 80 percent of the least of the following:

(1) The actual charge for the technical component of the service.

(2) The amount established for the technical component of a diagnostic bi-

lateral mammogram under the fee schedule for physicians' services.

(3) The technical component of the payment limit for screening mammography services described in paragraph (b)(3) of this section.

[55 FR 53521, Dec. 31, 1990, as amended at 59 FR 49833, Sept. 30, 1994; 66 FR 55328, Nov. 1, 2001]

§ 405.535 Special rule for nonparticipating physicians and suppliers furnishing screening mammography services before January 1, 2002.

The provisions in this section apply for screening mammography services provided from January 1, 1991 until December 31, 2001. Screening mammography services provided after December 31, 2001 are physician services pursuant to § 414.2 of this chapter paid under the physician fee schedule. If screening mammography services are furnished to a beneficiary by a nonparticipating physician or supplier that does not accept assignment, a limiting charge applies to the charges billed to the beneficiary. The limiting charge is the lesser of the following:

(a) 115 percent of the payment limit set forth in § 405.534(b)(3), (c)(3), and (d)(3) (limitations on the global service, professional component, and technical component of screening mammography services, respectively).

(b) The limiting charge for the global service, professional component, and technical component of a diagnostic bilateral mammogram under the fee schedule for physicians' services set forth at § 414.48(b) of this chapter.

[59 FR 49833, Sept. 30, 1994, as amended at 62 FR 59098, Oct. 31, 1997; 66 FR 55328, Nov. 1, 2001]

Subparts F– G [Reserved]

Subpart H—Appeals Under the Medicare Part B Program

AUTHORITY: Secs. 1102, 1866(j), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395cc(j), and 1395hh).

SOURCE: 77 FR 29028, May 16, 2012, unless otherwise noted.

§ 405.800 Appeals of CMS or a CMS contractor.

A CMS contractor's (that is, a carrier, Fiscal Intermediary or Medicare Administrative Contractor (MAC)) determination that a provider or supplier fails to meet the requirements for Medicare billing privileges.

(a) *Denial of a provider or supplier enrollment application.* If CMS or a CMS contractor denies a provider's or supplier's enrollment application, CMS or the CMS contractor notifies the provider or supplier by certified mail. The notice includes the following:

(1) The reason for the denial in sufficient detail to allow the provider or supplier to understand the nature of its deficiencies.

(2) The right to appeal in accordance with part 498 of this chapter.

(3) The address to which the written appeal must be mailed.

(b) *Revocation of Medicare billing privileges—(1) Notice of revocation.* If CMS or a CMS contractor revokes a provider's or supplier's Medicare billing privileges, CMS or a CMS contractor notifies the supplier by certified mail. The notice must include the following:

(i) The reason for the revocation in sufficient detail for the provider or supplier to understand the nature of its deficiencies.

(ii) The right to appeal in accordance with part 498 of this chapter.

(iii) The address to which the written appeal must be mailed.

(2) *Effective date of revocation.* The revocation of a provider's or supplier's billing privileges is effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider or supplier, except if the revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational. When a revocation is based on a Federal exclusion or debarment, felony conviction, license suspension or revocation, or the practice location is determined by CMS or its contractor not to be operational, the revocation is effective with the date of exclusion or debarment, felony conviction, license suspension or revocation or the date that CMS or its contractor determined

that the provider or supplier was no longer operational.

(3) *Payment after revocation.* Medicare does not pay, and the CMS contractor rejects, claims for services submitted with a service date on or after the effective date of a provider's or supplier's revocation.

(c) *Additional years applied to a reenrollment bar.* (1) If, under § 424.535(c)(2)(i) of this chapter, CMS or a CMS contractor applies additional years to a provider's or supplier's existing reenrollment bar, CMS or the CMS contractor notifies the provider or supplier by certified mail. The notice includes the following:

(i) The reason for the application of additional years in sufficient detail to allow the provider or supplier to understand the nature of the action.

(ii) The right to appeal in accordance with part 498 of this chapter.

(iii) The address to which the written appeal must be mailed.

(2) Paragraph (c)(1) of this section applies only to the years added to the existing reenrollment bar under § 424.535(c)(2)(i) of this chapter and not to the original length of the reenrollment bar, which is not subject to appeal.

[77 FR 29028, May 16, 2012, as amended at 84 FR 47852, Sept. 10, 2019]

§ 405.803 Appeals rights.

(a) A provider or supplier may appeal the initial determination to deny a provider or supplier's enrollment application, or if applicable, to revoke current billing privileges by following the procedures specified in part 498 of this chapter.

(b) The reconsideration of a determination to deny or revoke a provider or supplier's Medicare billing privileges is handled by a CMS Regional Office or a contractor hearing officer not involved in the initial determination.

(c) Providers and suppliers have the opportunity to submit evidence related to the enrollment action. Providers and suppliers must, at the time of their request, submit all evidence that they want to be considered.

(d) If supporting evidence is not submitted with the appeal request, the contractor contacts the provider or supplier to try to obtain the evidence.

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(e) If the provider or supplier fails to submit the evidence before the contractor issues its decision, the provider or supplier is precluded from introducing new evidence at higher levels of the appeals process.

§ 405.806 Impact of reversal of contractor determinations on claims processing.

(a) Claims for services furnished to Medicare beneficiaries during a period in which the supplier billing privileges were not effective are rejected.

(b) If a supplier is determined not to have qualified for billing privileges in one period but qualified in another, Medicare contractors process claims for services furnished to beneficiaries during the period for which the supplier was Medicare-qualified. Subpart C of this part sets forth the requirements for the recovery of overpayments.

(c) If a revocation of a supplier's billing privileges is reversed upon appeal, the supplier's billing privileges are reinstated back to the date that the revocation became effective.

(d) If the denial of a supplier's billing privileges is reversed upon appeal and becomes binding, then the appeal decision establishes the date that the supplier's billing privileges become effective.

§ 405.809 Reinstatement of provider or supplier billing privileges following corrective action.

(a) *General rule.* A provider or supplier—

(1) May only submit a corrective action plan for a revocation for non-compliance under § 424.535(a)(1) of this chapter; and

(2) Subject to paragraph (a)(1) of this section, has only one opportunity to correct all deficiencies that served as the basis of its revocation through a corrective action plan.

(b) *Review of a corrective action plan.* Subject to paragraph (a)(1) of this section, CMS or its contractor reviews a submitted corrective action plan and does either of the following:

(1) Reinstates the provider or supplier's billing privileges if the provider or supplier provides sufficient evidence to CMS or its contractor that it has

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complied fully with the Medicare requirements, in which case—

(i) The effective date of the reinstatement is based on the date the provider or supplier is in compliance with all Medicare requirements; and

(ii) CMS or its contractor may pay for services furnished on or after the effective date of the reinstatement.

(2) Refuses to reinstate a provider or supplier's billing privileges. The refusal of CMS or its contractor to reinstate a provider or supplier's billing privileges based on a corrective action plan is not an initial determination under part 498 of this chapter.

[79 FR 72530, Dec. 5, 2014]

§ 405.812 Effective date for DMEPOS supplier's billing privileges.

If a CMS contractor, contractor hearing officer, or ALJ determines that a DMEPOS supplier's denied enrollment application meets the standards in § 424.57 of this chapter and any other requirements that may apply, the determination establishes the effective date of the billing privileges as not earlier than the date the carrier made the determination to deny the DMEPOS supplier's enrollment application. Claims are rejected for services furnished before that effective date.

§ 405.815 Submission of claims.

A provider or supplier succeeding in having its enrollment application denial or billing privileges revocation reversed in a binding decision, or in having its billing privileges reinstated, may submit claims to the CMS contractor for services furnished during periods of Medicare qualification, subject to the limitations in § 424.44 of this chapter, regarding the timely filing of claims. If the claims previously were filed timely but were rejected, they are considered filed timely upon resubmission. Previously denied claims for items or services furnished during a period of denial or revocation may be resubmitted to CMS within 1 year after the date of reinstatement or reversal.

§ 405.818 Deadline for processing provider enrollment initial determinations.

Contractors approve or deny complete provider or supplier enrollment

applications to approval or denial within the following timeframes:

(a) *Initial enrollments.* Contractors process new enrollment applications within 180 days of receipt.

(b) *Revalidation of existing enrollments.* Contractors process revalidations within 180 days of receipt.

(c) *Change-of-information and reassignment of payment request.* Contractors process change-of-information and reassignment of payment requests within 90 days of receipt.

Subpart I—Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare (Part A and Part B)

SOURCE: 70 FR 11472, Mar. 8, 2005, unless otherwise noted.

§ 405.900 Basis and scope.

(a) *Statutory basis.* This subpart is based on the following provisions of the Act:

(1) Section 1869(a) through (e) and (g) of the Act.

(2) Section 1862(b)(2)(B)(viii) of the Act.

(b) *Scope.* This subpart establishes the requirements for appeals of initial determinations for benefits under Part A or Part B of Medicare, including the following:

(1) The initial determination of whether an individual is entitled to benefits under Part A or Part B. (Regulations governing reconsiderations of these initial determinations are at 20 CFR, part 404, subpart J).

(2) The initial determination of the amount of benefits available to an individual under Part A or Part B.

(3) Any other initial determination relating to a claim for benefits under Part A or Part B, including an initial determination made by a quality improvement organization under section 1154(a)(2) of the Act or by an entity under contract with the Secretary (other than a contract under section 1852 of the Act) to administer provisions of titles XVIII or XI of the Act.

[70 FR 11472, Mar. 8, 2005, as amended at 80 FR 10617, Feb. 27, 2015]

§ 405.902 Definitions.

For the purposes of this subpart, the term—

Additional documentation means any information requested by a contractor when conducting a prepayment review or post-payment review.

Additional documentation request (ADR) means a contractor's initial documentation request in reviewing claims selected for prepayment review or post-payment review.

ALJ means an Administrative Law Judge of the Department of Health and Human Services.

Appellant means the beneficiary, assignee or other person or entity that has filed and pursued an appeal concerning a particular initial determination. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Applicable plan means liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan.

Appointed representative means an individual appointed by a party to represent the party in a Medicare claim or claim appeal.

Assignee means:

(1) A supplier that furnishes items or services to a beneficiary and has accepted a valid assignment of a claim or

(2) A provider or supplier that furnishes items or services to a beneficiary, who is not already a party, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

Assignment of a claim means the transfer by a beneficiary of his or her claim for payment to the supplier in return for the latter's promise not to charge more for his or her services than what the carrier finds to be the Medicare-approved amount, as provided in §§ 424.55 and 424.56 of this chapter.

Assignment of appeal rights means the transfer by a beneficiary of his or her right to appeal under this subpart to a provider or supplier who is not already a party, as provided in section 1869(b)(1)(C) of the Act.

Assignor means a beneficiary whose provider of services or supplier has taken assignment of a claim or an appeal of a claim.