

§ 405.912

42 CFR Ch. IV (10–1–23 Edition)

revoked is not good cause for missing a deadline or not appearing at a hearing.

[70 FR 11472, Mar. 8, 2005, as amended at 80 FR 10617, Feb. 27, 2015; 82 FR 5106, Jan. 17, 2017; 84 FR 19869, May 7, 2019]

§ 405.912 Assignment of appeal rights.

(a) *Who may be an assignee.* Only a provider, or supplier that—

(1) Is not a party to the initial determination as defined in § 405.906; and

(2) Furnished an item or service to the beneficiary may seek assignment of appeal rights from the beneficiary for that item or service.

(b) *Who may not be an assignee.* An individual or entity who is not a provider or supplier may not be an assignee. A provider or supplier that furnishes an item or service to a beneficiary may not seek assignment for that item or service when considered a party to the initial determination as defined in § 405.906.

(c) *Requirements for a valid assignment of appeal right.* The assignment of appeal rights must—

(1) Be executed using a CMS standard form;

(2) Be in writing and signed by both the beneficiary assigning his or her appeal rights and by the assignee;

(3) Indicate the item or service for which the assignment of appeal rights is authorized;

(4) Contain a waiver of the assignee's right to collect payment from the assignor for the specific item or service that are the subject of the appeal except as set forth in paragraph (d)(2) of this section; and

(5) Be submitted at the same time the request for redetermination or other appeal is filed.

(d) *Waiver of right to collect payment.*

(1) Except as specified in paragraph (d)(2) of this section, the assignee must waive the right to collect payment for the item or service for which the assignment of appeal rights is made. If the assignment is revoked under paragraph (g)(2) or (g)(3) of this section, the waiver of the right to collect payment nevertheless remains valid. A waiver of the right to collect payment remains in effect regardless of the outcome of the appeal decision.

(2) The assignee is not prohibited from recovering payment associated

with coinsurance or deductibles or when an advance beneficiary notice is properly executed.

(e) *Duration of a valid assignment of appeal rights.* Unless revoked, the assignment of appeal rights is valid for all administrative and judicial review associated with the item or service as indicated on the standard CMS form, even in the event of the death of the assignor.

(f) *Rights of the assignee.* When a valid assignment of appeal rights is executed, the assignor transfers all appeal rights involving the particular item or service to the assignee. These include, but are not limited to—

(1) Obtaining information about the claim to the same extent as the assignor;

(2) Submitting evidence;

(3) Making statements about facts or law; and

(4) Making any request, or giving, or receiving any notice about appeal proceedings.

(g) *Revocation of assignment.* When an assignment of appeal rights is revoked, the rights to appeal revert to the assignor. An assignment of appeal rights may be revoked in any of the following ways:

(1) *In writing by the assignor.* The revocation of assignment must be delivered to the adjudicator and the assignee, and is effective on the date of receipt by the adjudicator.

(2) By abandonment if the assignee does not file an appeal of an unfavorable decision.

(3) By act or omission by the assignee that is determined by an adjudicator to be contrary to the financial interests of the assignor.

(h) *Responsibilities of the assignee.* Once the assignee files an appeal, the assignee becomes a party to the appeal. The assignee must meet all requirements for appeals that apply to any other party.

[70 FR 11472, Mar. 8, 2005, as amended at 70 FR 37702, June 30, 2005]

INITIAL DETERMINATIONS

§ 405.920 Initial determinations.

After a claim is filed with the appropriate contractor in the manner and

form described in subpart C of part 424 of this chapter, the contractor must—

(a) Determine if the items and services furnished are covered or otherwise reimbursable under title XVIII of the Act;

(b) Determine any amounts payable and make payment accordingly; and

(c) Notify the parties to the initial determination of the determination in accordance with § 405.921.

§ 405.921 Notice of initial determination.

(a) *Notice of initial determination sent to the beneficiary.* (1) The notice must be written in a manner calculated to be understood by the beneficiary, and sent to the last known address of the beneficiary.

(2) *Content of the notice.* The notice of initial determination must contain all of the following:

(i) The reasons for the determination, including whether a local medical review policy, a local coverage determination, or national coverage determination was applied.

(ii) The procedures for obtaining additional information concerning the contractor's determination, such as a specific provision of the policy, manual, law or regulation used in making the determination.

(iii) Information on the right to a redetermination if the beneficiary is dissatisfied with the outcome of the initial determination and instructions on how to request a redetermination.

(iv) Any other requirements specified by CMS.

(b) *Notice of initial determination sent to providers and suppliers.* (1) An electronic or paper remittance advice (RA) notice is the notice of initial determination sent to providers and suppliers that accept assignment.

(i) The electronic RA must comply with the format and content requirements of the standard adopted for national use by covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and related CMS manual instructions.

(ii) When a paper RA is mailed, it must comply with CMS manual instructions that parallel the HIPAA data content and coding requirements.

(2) The notice of initial determination must contain all of the following:

(i) The basis for any full or partial denial determination of services or items on the claim.

(ii) Information on the right to a redetermination if the provider or supplier is dissatisfied with the outcome of the initial determination.

(iii) All applicable claim adjustment reason and remark codes to explain the determination.

(iv) The source of the RA and who may be contacted if the provider or supplier requires further information.

(v) All content requirements of the standard adopted for national use by covered entities under HIPAA.

(vi) Any other requirements specified by CMS.

(c) *Notice of initial determination sent to an applicable plan—*(1) *Content of the notice.* The notice of initial determination under § 405.924(b)(16) must contain all of the following:

(i) The reasons for the determination.

(ii) The procedures for obtaining additional information concerning the contractor's determination, such as a specific provision of the policy, manual, law or regulation used in making the determination.

(iii) Information on the right to a redetermination if the liability insurance (including self-insurance), no-fault insurance, or workers' compensation law or plan is dissatisfied with the outcome of the initial determination and instructions on how to request a redetermination.

(iv) Any other requirements specified by CMS.

(2) [Reserved]

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

§ 405.922 Time frame for processing initial determinations.

The contractor issues initial determinations on clean claims within 30 calendar days of receipt if they are submitted by or on behalf of the beneficiary who received the items and/or services; otherwise, interest must be paid at the rate specified at 31 U.S.C. 3902(a) for the period beginning on the day after the required payment date