

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

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and ending on the date payment is made.

[70 FR 11472, Mar. 8, 2005, as amended at 74 FR 65333, Dec. 9, 2009]

§ 405.924 Actions that are initial determinations.

(a) *Applications and entitlement of individuals.* SSA makes initial determinations and processes reconsiderations with respect to an individual on the following:

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance under Medicare.

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA specifies in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence).

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance, or a denial of a request for cancellation of a request for withdrawal.

(4) A determination as to whether an individual, previously determined as entitled to hospital or supplementary medical insurance, is no longer entitled to those benefits, including a determination based on nonpayment of premiums.

(5) An adjustment of premium for hospital or supplementary medical insurance as outlined in §§ 406.32(d), 408.20(e), and 408.22 of this chapter, and 20 CFR 418.1301.

(b) *Claims made by or on behalf of beneficiaries.* The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment or other submission does not meet the requirements for a Medicare claim as defined in § 424.32 of this chapter, is not considered an initial determination. An initial determination for purposes of this subpart includes, but is not limited to, determinations with respect to any of the following:

(1) If the items and/or services furnished are covered under title XVIII.

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, if the beneficiary, or supplier who accepts assignment under § 424.55 of this chapter knew, or could reasonably have expected to know at the time the items or services were furnished, that the items or services were not covered.

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, if the beneficiary or physician knew, or could reasonably have expected to know at the time the services were furnished, that the services were not covered.

(4) Whether the deductible is met.

(5) The computation of the coinsurance amount.

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care.

(7) Periods of hospice care used.

(8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, and partial hospitalization services.

(9) The beginning and ending of a spell of illness, including a determination made under the presumptions established under § 409.60(c)(2) of this chapter, and as specified in § 409.60(c)(4) of this chapter.

(10) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with § 476.86(c)(1) of this chapter.

(11) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there was an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof.

(12) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate—

(i) When an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) was made for an individual; or