

§ 405.927

42 CFR Ch. IV (10–1–23 Edition)

access to judicial review provided in § 405.990.

(e) Any determination regarding whether a Medicare overpayment claim must be compromised, or collection action terminated or suspended under the Federal Claims Collection Act of 1966, as amended.

(f) Determinations regarding the transfer or discharge of residents of skilled nursing facilities in accordance with § 483.5 definition of ‘transfer and discharge’ and § 483.15 of this chapter.

(g) Determinations regarding the readmission screening and annual resident review processes required by subparts C and E of part 483 of this chapter.

(h) Determinations for a waiver of Medicare Secondary Payer recovery under section 1862(b) of the Act.

(i) Determinations for a waiver of interest.

(j) Determinations for a finding regarding the general applicability of the Medicare Secondary Payer provisions (as opposed to the application of these provisions to a particular claim or claims for Medicare payment for benefits).

(k) Except as specified in § 405.924(b)(16), determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery against an entity that was or is required or responsible (directly, as an insurer or self-insurer; as a third party administrator; as an employer that sponsors, contributes to or facilitates a group health plan or a large group health plan; or otherwise) to make payment for services or items that were already reimbursed by the Medicare program.

(l) A contractor’s, QIC’s, ALJ’s or attorney adjudicator’s, or Council’s determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, decision, or review decision.

(m) Determinations that CMS or its contractors may participate in the proceedings on a request for an ALJ hearing or act as parties in an ALJ hearing or Council review.

(n) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the

beneficiary or the beneficiary’s subrogee.

(o) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under part 424 of this chapter.

(p) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section 1893(f)(3)(A) of the Act.

(q) A contractor’s prior determination related to coverage of physicians’ services.

(r) Requests for anticipated payment under the home health prospective payment system under § 409.43(c)(ii)(2) of this chapter.

(s) Claim submissions on forms or formats that are incomplete, invalid, or do not meet the requirements for a Medicare claim and returned or rejected to the provider or supplier.

(t) A contractor’s prior authorization determination with regard to—

(1) Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)); and

(2) Hospital outpatient department (OPD) services.

(u) Issuance of notice to an individual entitled to Medicare benefits under Title XVIII of the Act when such individual received observation services as an outpatient for more than 24 hours, as specified under § 489.20(y) of this chapter.

[70 FR 11472, Mar. 8, 2005, as amended at 70 FR 37702, June 30, 2005; 80 FR 10618, Feb. 27, 2015; 80 FR 81706, Dec. 30, 2015; 81 FR 57267, Aug. 22, 2016; 81 FR 68847, Oct. 4, 2016; 82 FR 5107, Jan. 17, 2017; 84 FR 19869, May 7, 2019; 84 FR 61490, Nov. 12, 2019]

§ 405.927 Initial determinations subject to the reopenings process.

Minor errors or omissions in an initial determination must be corrected only through the contractor’s reopenings process under § 405.980(a)(3).

§ 405.928 Effect of the initial determination.

(a) An initial determination described in § 405.924(a) is binding unless it is revised or reconsidered in accordance with 20 CFR 404.907, or revised as a result of a reopening in accordance with 20 CFR 404.988.