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.

Attorney Adjudicator means a licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, and authorized to take the actions provided for in this subpart on requests for ALJ hearing and requests for reviews of QIC dismissals.

Authorized representative means an individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. The authorized representative will have all of the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process.

Beneficiary means an individual who is enrolled to receive benefits under Medicare Part A or Part B.

Carrier means an organization that has entered into a contract with the Secretary in accordance to section 1842 of the Act and is authorized to make determinations for Part B of title XVIII of the Act.

Clean claim means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under title XVIII within the time periods specified in sections 1816(c) and 1842(c) of the Act.

Contractor means an entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Council stands for the Medicare Appeals Council within the Departmental Appeals Board of the U.S. Department of Health and Human Services.

Family member means for purposes of the QIC reconsideration panel under § 405.968 the following persons as they relate to the physician or healthcare provider.

(1) The spouse (other than a spouse who is legally separated from the physician or health care professional under a decree of divorce or separate maintenance);

(2) Children (including stepchildren and legally adopted children);

(3) Grandchildren;

(4) Parents; and

(5) Grandparents.

Fiscal Intermediary means an organization that has entered into a contract with CMS in accordance with section 1816 of the Act and is authorized to make determinations and payments for Part A of title XVIII of the Act, and Part B provider services as specified in § 421.5(c) of this chapter.

OMHA stands for the Office of Medicare Hearings and Appeals within the U.S. Department of Health and Human Services, which administers the ALJ hearing process in accordance with section 1869(b)(1) of the Act.

Party means an individual or entity listed in § 405.906 that has standing to appeal an initial determination and/or a subsequent administrative appeal determination.

Post-payment medical review (or post-payment review) means a review that occurs after payment is made on the selected claim to determine whether the initial determination for payment was appropriate.

Prepayment medical review (or prepayment review) means a review that occurs before an initial determination for payment is made on the selected claim to determine whether payment should be made.

Provider means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that has in effect an agreement to participate in Medicare, or clinic, rehabilitation agency, or public health agency that has in effect a similar agreement, but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Qualified Independent Contractor (QIC) means an entity which contracts with the Secretary in accordance with section 1869 of the Act to perform reconsiderations under § 405.960 through § 405.978.

Quality Improvement Organization (QIO) means an entity that contracts with the Secretary in accordance with sections 1152 and 1153 of the Act and 42 CFR subchapter F, to perform the functions described in section 1154 of the

Act and 42 CFR subchapter F, including expedited determinations as described in § 405.1200 through § 405.1208.

Reliable evidence means evidence that is relevant, credible, and material.

Remand means to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Similar fault means to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim as defined in part 411 of this chapter.

Supplier means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under Medicare.

Vacate means to set aside a previous action.

[70 FR 11472, Mar. 8, 2005, as amended at 74 FR 65333, Dec. 9, 2009; 80 FR 10617, Feb. 27, 2015; 82 FR 5106, Jan. 17, 2017; 86 FR 65659, Nov. 19, 2021]

§ 405.903 Prepayment review.

(a) A contractor may select a claim(s) for prepayment review.

(b) In conducting a prepayment review, a contractor may issue additional documentation requests to a provider or supplier.

(1) A provider or supplier will be provided 45 calendar days to submit additional documentation in response to a contractor's request, except as stated in paragraph (b)(2) and (c) of this section.

(2) A contractor may accept documentation received after 45-calendar days for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation.

(c) A provider or supplier will be provided 30 calendar days to submit additional documentation in response to a UPIC's request for additional documentation. A UPIC may accept documentation received after the 30 calendar days for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the UPIC deems good cause in accepting the documentation.

(d) A contractor's prepayment review will result in an initial determination under § 405.920.

[86 FR 65660, Nov. 19, 2021]

§ 405.904 Medicare initial determinations, redeterminations and appeals: General description.

(a) *General overview*—(1) *Entitlement appeals.* The SSA makes an initial determination on an application for Medicare benefits and/or entitlement of an individual to receive Medicare benefits. A beneficiary who is dissatisfied with the initial determination may request, and SSA will perform, a reconsideration in accordance with 20 CFR part 404, subpart J if the requirements for obtaining a reconsideration are met. Following the reconsideration, the beneficiary may request a hearing before an ALJ under this subpart (42 CFR part 405, subpart I). If the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, or if the beneficiary requests a hearing and no hearing is conducted, and the beneficiary is dissatisfied with the decision of an ALJ or an attorney adjudicator, he or she may request the Council to review the case. Following the action of the Council, the beneficiary may be entitled to file suit in Federal district court.

(2) *Claim appeals.* The Medicare contractor makes an initial determination when a claim for Medicare benefits under Part A or Part B is submitted. A beneficiary who is dissatisfied with the initial determination may request that the contractor perform a redetermination of the claim if the requirements for obtaining a redetermination are met. Following the contractor's redetermination, the beneficiary may request, and the Qualified Independent Contractor (QIC) will perform, a reconsideration of the claim if the requirements for obtaining a reconsideration