

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.

(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 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