

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