

## § 405.903

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.

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(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 are met. Following the reconsideration, the beneficiary may request a hearing before an ALJ. If the beneficiary obtains a hearing before the 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 attorney adjudicator, he or she may request the Council to review the case. If the Council reviews the case and issues a decision, and the beneficiary is dissatisfied with the decision, the beneficiary may file suit in Federal district court if the amount remaining in controversy and the other requirements for judicial review are met.

(b) *Non-beneficiary appellants.* In general, the procedures described in paragraph (a) of this section are also available to parties other than beneficiaries either directly or through a representative acting on a party's behalf, consistent with the requirements of this subpart I. A provider generally has the right to judicial review only as provided under section 1879(d) of the Act; that is, when a determination involves a finding that services are not covered because—

(1) They were custodial care (see § 411.15(g) of this chapter); they were not reasonable and necessary (see § 411.15(k) of this chapter); they did not qualify as covered home health services because the beneficiary was not confined to the home or did not need skilled nursing care on an intermittent basis (see § 409.42(a) and (c)(1) of this chapter); or they were hospice services provided to a non-terminally ill individual (see § 418.22 of this chapter); and

(2) Either the provider or the beneficiary, or both, knew or could reasonably be expected to know that those

services were not covered under Medicare.

[70 FR 11472, Mar. 8, 2005, as amended at 82 FR 5106, Jan. 17, 2017]

**§ 405.906 Parties to the initial determinations, redeterminations, reconsiderations, hearings, and reviews.**

(a) *Parties to the initial determination.* The parties to the initial determination are the following individuals and entities:

(1) A beneficiary who files a claim for payment under Medicare Part A or Part B or has had a claim for payment filed on his or her behalf, or in the case of a deceased beneficiary, when there is no estate, any person obligated to make or entitled to receive payment in accordance with part 424, subpart E of this chapter. Payment by a third party payer does not entitle that entity to party status.

(2) A supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the claim.

(3) A provider of services who files a claim for items or services furnished to a beneficiary.

(4) An applicable plan for an initial determination under § 405.924(b)(16) where Medicare is pursuing recovery directly from the applicable plan. The applicable plan is the sole party to an initial determination under § 405.924(b)(16) (that is, where Medicare is pursuing recovery directly from the applicable plan).

(b) *Parties to the redetermination, reconsideration, proceedings on a request for hearing, and Council review.* The parties to the redetermination, reconsideration, proceedings on a request for hearing, and Council review are—

(1) The parties to the initial determination in accordance with paragraph (a) of this section, except under paragraph (a)(1) of this section where a beneficiary has assigned appeal rights under § 405.912;

(2) A State agency in accordance with § 405.908;

(3) A provider or supplier that has accepted an assignment of appeal rights from the beneficiary according to § 405.912;