

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;

(4) A non-participating physician not billing on an assigned basis who, in accordance with section 1842(l) of the Act, may be liable to refund monies collected for services furnished to the beneficiary because those services were denied on the basis of section 1862(a)(1) of the Act; and

(5) A non-participating supplier not billing on an assigned basis who, in accordance with sections 1834(a)(18) and 1834(j)(4) of the Act, may be liable to refund monies collected for items furnished to the beneficiary.

(c) *Appeals by providers and suppliers when there is no other party available.* If a provider or supplier is not already a party to the proceeding in accordance with paragraphs (a) and (b) of this section, a provider of services or supplier may appeal an initial determination relating to services it rendered to a beneficiary who subsequently dies if there is no other party available to appeal the determination. This paragraph (c) does not apply to an initial determination with respect to an applicable plan under § 405.924(b)(16).

[70 FR 11472, Mar. 8, 2005, as amended at 80 FR 10617, Feb. 27, 2015; 82 FR 5106, Jan. 17, 2017]

§ 405.908 Medicaid State agencies.

When a beneficiary is enrolled to receive benefits under both Medicare and Medicaid, the Medicaid State agency may file a request for an appeal with respect to a claim for items or services furnished to a dually eligible beneficiary only for services for which the Medicaid State agency has made payment, or for which it may be liable. A Medicaid State agency is considered a party only when it files a timely redetermination request with respect to a claim for items or services furnished to a beneficiary in accordance with 42 CFR parts 940 through 958. If a State agency files a request for redetermination, it may retain party status at the QIC, OMHA, Council, and judicial review levels.

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

§ 405.910 Appointed representatives.

(a) *Scope of representation.* An appointed representative may act on be-

half of an individual or entity in exercising his or her right to an initial determination or appeal. Appointed representatives do not have party status and may take action only on behalf of the individual or entity that they represent.

(b) *Persons not qualified.* A party may not name as an appointed representative, an individual who is disqualified, suspended, or otherwise prohibited by law from acting as a representative in any proceedings before DHHS, or in entitlement appeals, before SSA.

(c) *Completing a valid appointment.* For purposes of this subpart, an appointment of representation must:

(1) Be in writing and signed and dated by both the party and individual agreeing to be the representative;

(2) Provide a statement appointing the representative to act on behalf of the party, and in the case of a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative.

(3) Include a written explanation of the purpose and scope of the representation;

(4) Contain both the party's and appointed representative's name, phone number, and address;

(5) Identify the beneficiary's Medicare number when the beneficiary is the party appointing a representative, or identify the Medicare National Provider Identifier number of the provider or supplier that furnished the item or service when the provider or supplier is the party appointing a representative;

(6) Include the appointed representative's professional status or relationship to the party;

(7) Be filed with the entity processing the party's initial determination or appeal.

(d) *Curing a defective appointment of representative.* (1) If any one of the seven elements named in paragraph (c) of this section is missing from the appointment, the adjudicator should contact the party and provide a description of the missing documentation or information.

(2) Unless the defect is cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or