

§ 405.922 Time frame for processing initial determinations.

The contractor issues initial determinations on clean claims within 30 calendar days of receipt if they are submitted by or on behalf of the beneficiary who received the items and/or services; otherwise, interest must be paid at the rate specified at 31 U.S.C. 3902(a) for the period beginning on the day after the required payment date and ending on the date payment is made.

[70 FR 11472, Mar. 8, 2005, as amended at 74 FR 65333, Dec. 9, 2009]

§ 405.924 Actions that are initial determinations.

(a) *Applications and entitlement of individuals.* SSA makes initial determinations and processes reconsiderations with respect to an individual on the following:

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance under Medicare.

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA specifies in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence).

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance, or a denial of a request for cancellation of a request for withdrawal.

(4) A determination as to whether an individual, previously determined as entitled to hospital or supplementary medical insurance, is no longer entitled to those benefits, including a determination based on nonpayment of premiums.

(5) An adjustment of premium for hospital or supplementary medical insurance as outlined in §§ 406.32(d), 408.20(e), and 408.22 of this chapter, and 20 CFR 418.1301.

(b) *Claims made by or on behalf of beneficiaries.* The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a re-

quest for payment or other submission does not meet the requirements for a Medicare claim as defined in § 424.32 of this chapter, is not considered an initial determination. An initial determination for purposes of this subpart includes, but is not limited to, determinations with respect to any of the following:

(1) If the items and/or services furnished are covered under title XVIII.

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, if the beneficiary, or supplier who accepts assignment under § 424.55 of this chapter knew, or could reasonably have expected to know at the time the items or services were furnished, that the items or services were not covered.

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, if the beneficiary or physician knew, or could reasonably have expected to know at the time the services were furnished, that the services were not covered.

(4) Whether the deductible is met.

(5) The computation of the coinsurance amount.

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care.

(7) Periods of hospice care used.

(8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, and partial hospitalization services.

(9) The beginning and ending of a spell of illness, including a determination made under the presumptions established under § 409.60(c)(2) of this chapter, and as specified in § 409.60(c)(4) of this chapter.

(10) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with § 476.86(c)(1) of this chapter.

(11) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there

was an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof.

(12) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate—

(i) When an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) was made for an individual; or

(ii) For a Medicare Secondary Payer recovery claim against a beneficiary or against a provider or supplier.

(13) If a particular claim is not payable by Medicare based upon the application of the Medicare Secondary Payer provisions of section 1862(b) of the Act.

(14) Under the Medicare Secondary Payer provisions of sections 1862(b) of the Act that Medicare has a recovery claim against a provider, supplier, or beneficiary for services or items that were already paid by the Medicare program, except when the Medicare Secondary Payer recovery claim against the provider or supplier is based upon failure to file a proper claim as defined in part 411 of this chapter because this action is a reopening.

(15) A claim not payable to a beneficiary for the services of a physician who has opted-out.

(16) Under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery claim if Medicare is pursuing recovery directly from an applicable plan. That is, there is an initial determination with respect to the amount and existence of the recovery claim.

(c) *Determinations by QIOs.* An initial determination for purposes of this subpart also includes a determination made by a QIO that:

(1) A provider can terminate services provided to an individual when a physician certified that failure to continue the provision of those services is likely to place the individual's health at significant risk; or

(2) A provider can discharge an individual from the provider of services.

[70 FR 11472, Mar. 8, 2005, as amended at 74 FR 65333, Dec. 9, 2009; 79 FR 68001, Nov. 13, 2014; 80 FR 10618, Feb. 27, 2015; 83 FR 16721, Apr. 16, 2018]

§ 405.925 Decisions of utilization review committees.

(a) *General rule.* A decision of a utilization review committee is a medical determination by a staff committee of the provider or a group similarly composed and does not constitute a determination by the Secretary within the meaning of section 1869 of the Act. The decision of a utilization review committee may be considered by CMS along with other pertinent medical evidence in determining whether or not an individual has the right to have payment made under Part A of title XVIII.

(b) *Applicability under the prospective payment system.* CMS may consider utilization review committee decisions related to inpatient hospital services paid for under the prospective payment system (see part 412 of this chapter) only as those decisions concern:

(1) The appropriateness of admissions resulting in payments under subparts D, E and G of part 412 of this chapter.

(2) The covered days of care involved in determinations of outlier payments under § 412.80(a)(1)(i) of this chapter; and

(3) The necessity of professional services furnished in high cost outliers under § 412.80(a)(1)(ii) of this chapter.

[48 FR 39831, Sept. 1, 1983. Redesignated at 77 FR 29028, May 16, 2012]

§ 405.926 Actions that are not initial determinations.

Actions that are not initial determinations and are not appealable under this subpart include, but are not limited to the following:

(a) Any determination for which CMS has sole responsibility, for example one of the following:

(1) If an entity meets the conditions for participation in the program.

(2) If an independent laboratory meets the conditions for coverage of services.

(3) Determination under the Medicare Secondary Payer provisions of section 1862(b) of the Act of the debtor for a particular recovery claim.

(b) The coinsurance amounts prescribed by regulation for outpatient services under the prospective payment system.