

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.