

skilled nursing care, home health, hospice, and partial hospitalization services;

(10) 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;

(11) 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;

(12) 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;

(13) 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.

(14) 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.

(15) 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.

(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 physi-

cian 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.

§ 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—

(a) Any determination for which CMS has sole responsibility, for example—

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

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

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

(c) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a carrier has sole responsibility under Part B such as the establishment of a fee schedule set forth in part 414 of this chapter, or an inherent reasonableness adjustment pursuant to § 405.502(g), and any issue regarding the cost report settlement process under Part A;

(d) Whether an individual's appeal meets the qualifications for expedited access by judicial review provided in § 405.990;

(e) Any determination regarding whether a Medicare overpayment claim must be compromised, or collection action terminated or suspended under the Federal Claims Collection Act of 1966, as amended;

(f) Determinations regarding the transfer or discharge of residents of skilled nursing facilities in accordance with § 483.12 of this chapter;

(g) Determinations regarding the readmission screening and annual resident review processes required by subparts C and E of part 483 of this chapter;

(h) Determinations for a waiver of Medicare Secondary Payer recovery under section 1862(b) of the Act;

(i) Determinations for a waiver of interest;

§ 405.927

(j) Determinations for a finding regarding the general applicability of the Medicare Secondary Payer provisions (as opposed to the application of these provisions to a particular claim or claims for Medicare payment for benefits);

(k) Determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery against an entity that was or is required or responsible (directly, as an insurer or self-insurer, as a third party administrator, as an employer that sponsors or contributes to a group health plan or a large group health plan, or otherwise,) to make payment for services or items that were already reimbursed by the Medicare program;

(l) A contractor's, QIC's, ALJ's, or MAC's determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision;

(m) Determinations that CMS or its contractors may participate in or act as parties in an ALJ hearing or MAC review;

(n) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary's subrogee;

(o) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under part 424 of this chapter;

(p) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section 1893(f)(3)(A) of the Act;

(q) A contractor's prior determination related to coverage of physicians' services;

(r) Requests for anticipated payment under the home health prospective payment system under § 409.43(c)(ii)(2) of this chapter; and

(s) Claim submissions on forms or formats that are incomplete, invalid, or do not meet the requirements for a Medicare claim and returned or rejected to the provider or supplier.

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42 CFR Ch. IV (10-1-06 Edition)

§ 405.927 Initial determinations subject to the reopenings process.

Minor errors or omissions in an initial determination must be corrected only through the contractor's reopenings process under § 405.980(a)(3).

§ 405.928 Effect of the initial determination.

(a) An initial determination described in § 405.924(a) is binding unless it is revised or reconsidered in accordance with 20 CFR 404.907, or revised as a result of a reopening in accordance with 20 CFR 404.988.

(b) An initial determination described in § 405.924(b) is binding upon all parties to the initial determination unless—

(1) A redetermination is completed in accordance with § 405.940 through § 405.958; or

(2) The initial determination is revised as a result of a reopening in accordance with § 405.980.

(c) An initial determination listed in § 405.924(b) where a party submits a timely, valid request for redetermination under § 405.942 through § 405.944 must be processed as a redetermination under § 405.948 through § 405.958 unless the initial determination involves a clerical error or other minor error or omission.

REDETERMINATIONS

§ 405.940 Right to a redetermination.

A person or entity that may be a party to a redetermination in accordance with § 405.906(b) and that is dissatisfied with an initial determination may request a redetermination by a contractor in accordance with § 405.940 through § 405.958, regardless of the amount in controversy.

§ 405.942 Time frame for filing a request for a redetermination.

(a) *Time frame for filing a request.* Except as provided in paragraph (b) of this section, any request for redetermination must be filed within 120 calendar days from the date a party receives the notice of the initial determination.

(1) For purposes of this section, the date of receipt of the initial determination will be presumed to be 5 days after