

§ 405.872 Authority of representatives.

A representative, appointed and qualified as provided in §§ 405.870 and 405.871, may make or give, on behalf of the party he represents, any request or notice relative to any proceeding before the carrier including review and hearing. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to the claim of such party to the same extent as such party. Notice to any party or any action, determination, or decision, or request to any party for the production of evidence, shall be sent to the representative of such party.

§ 405.874 Appeals of carrier decisions that supplier standards are not met.

(a) An entity serving as a National Supplier Clearinghouse must act promptly to determine if any entity submitting a request for a billing number as a Medicare supplier of part B items meets the standards set forth in part 424. Effective July 1, 1993, the National Supplier Clearinghouse must accept, reject or request additional information within 15 days of the receipt of an enrollment application.

(b) If the National Supplier Clearinghouse disallows an entity's request for a billing number or revokes, with the concurrence of HCFA, an entity's billing number, the National Supplier Clearinghouse notifies the entity by certified mail. Revocation is effective 15 days after the National Supplier Clearinghouse mails notice of its determination. The carrier disallows payment for items furnished by the supplier beginning with that effective date. The notice must inform the entity of the reason for the rejection or revocation, its right to appeal, the date by which it must file that appeal (90 days after the postmark of the notice) and the address to which the appeal must be sent in writing.

(c) A fair hearing officer not involved in the original determination to disallow an entity's request for a billing number, or to revoke an entity's billing number, must schedule a hearing to be held within one week of receipt of an appeal, or later at the request of the

entity. Both the entity and carrier may offer evidence. The hearing officer issues notice of his/her decision within 2 weeks of the hearing. The notice is sent by certified letter to HCFA, the carrier, and the appealing entity. This notice must include information about the supplier's further right to appeal, the carrier's right to appeal, the date by which the appeal must be filed (90 days after the postmark of the notice) and the address to which the appeals must be sent in writing. Either the carrier or entity may appeal the hearings officer's decision to HCFA.

(d) A HCFA official, designated by the Administrator of HCFA, must make an appeal decision based on the evidence presented to the fair hearing officer and his or her decision. The HCFA official requests any additional information he or she deems necessary from either the carrier or the entity within two weeks of receipt by the HCFA of the appeal. Notice of the HCFA official's decision—

(1) Is issued within two weeks of when the last information is received is received by the HCFA official, or four weeks of when the information is requested, whichever is shorter, unless the party appealing the fair hearing decision requests a delay;

(2) Is sent by the HCFA official by certified mail to both the carrier and the entity; and

(3) Contains information on any further appeals the entity and carrier may have.

(e) A billing number is not issued, or remains revoked, and payment is not made, for items or services furnished by any entity which a carrier determines does not qualify for a billing number, until the carrier (upon re-application of the entity), a fair hearing officer, or a HCFA official designated to hear such appeals, determines that the entity qualifies for a billing number. Any claims for items or services furnished after revocation of the supplier's billing number and submitted by the entity during the appeals period are held and not processed, i.e., are neither approved, denied or developed, until all administrative appeals have been exhausted. If an entity is determined not to have qualified for a billing number in one period but to

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have qualified in another, the carrier pays for claims for items sold or rented to beneficiaries during the period the entity qualified as a supplier. If there is evidence of an overpayment, see subpart C of part 405 of this Chapter.

(f) A billing number may be reinstated after revocation when an entity completes a corrective action plan, to which HCFA has agreed, and provided sufficient assurance of its intent to comply fully with the supplier standards.

[57 FR 27305, June 18, 1992]

§ 405.877 Appeal of a categorization of a device.

(a) HCFA's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under § 405.203 is a national coverage decision under section 1862(a)(1) of the Act.

(b) HCFA's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under § 405.203 is an aspect of an initial determination that, under section 1862 of the Act, payment may not be made.

(c) In accordance with section 1869(b)(3)(A) of the Act, HCFA's acceptance of the FDA categorization of a device as an experimental/investigational (Category A) device under § 405.203 may not be reviewed by an administrative law judge.

[60 FR 48424, Sept. 19, 1995]

Subparts I–Q—[Reserved]

Subpart R—Provider Reimbursement Determinations and Appeals

AUTHORITY: Secs. 205, 1102, 1814(b), 1815(a), 1833, 1861(v), 1871, 1872, 1878, and 1886 of the Social Security Act (42 U.S.C. 405, 1302, 1395f(b), 1395g(a), 1395l, 1395x(v), 1395hh, 1395ii, 1395oo, and 1395ww).

SOURCE: 39 FR 34515, Sept. 26, 1974, unless otherwise noted. Redesignated at 42 FR 52826, Sept. 30, 1977.

§ 405.1801 Introduction.

(a) *Definitions.* As used in this subpart:

Administrator means the Administrator or Deputy Administrator of HCFA.

Administrator's review means that review provided for in section 1878(f) of the Act (42 U.S.C. 1395oo(f)) and § 405.1875.

Board means the Provider Reimbursement Review Board established in accordance with section 1878 of the Act (42 U.S.C. 1395oo) and § 405.1845.

Board hearing means that hearing provided for in section 1878(a) of the Act (42 U.S.C. 1395oo(a)), and § 405.1835.

Date of filing and *date of submission of materials* mean the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined in this subpart.

Date of receipt means the date on the return receipt of "return receipt requested" mail, unless otherwise defined in this subpart.

Intermediary determination means the following:

(1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

(2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.

(3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary", as those phrases are used in section 1878(a) of the Act.

(4) For purposes of § 405.376 concerning claims collection activities, the term does not include an action by HCFA with respect to a compromise of